Two Tragedies

HOLDING SYSTEMS ACCOUNTABLE

SPECIAL INVESTIGATION REPORT | MAY 2014

SASKATCHEWAN advocate

a Voice for Children and Youth

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Letter of Transmittal

May 14, 2014

The Honourable Dan D'Autremont
Speaker of the Legislative Assembly
Legislative Building
2405 Legislative Drive
Regina SK S4S 0B3

Dear Mr. Speaker:

In accordance with Section 29 of *The Advocate for Children and Youth Act*, it is my duty and privilege to submit to you and the members of the Legislative Assembly of Saskatchewan this special investigation report: *Two Tragedies: Holding Systems Accountable.*

Respectfully submitted,

Bob Pringle

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This report examines the lives of two young boys we are calling "Sam" and "Derek", whose paths crossed tragically on August 21, 2013. As per the legislation governing this office, we have not identified the real names of these children. The report includes a review of the services both boys received from the Ministry of Social Services (MSS) and the Yorkton Tribal Council Child and Family Services Inc. (the Agency) leading up to Sam's death. It is also a review of the mechanisms and structures for accountability by those responsible to ensure that quality standards for child protection are being upheld in this province.

Sam was six years old at the time of his death. He was in the care of the Ministry of Social Services (MSS) and was living in a foster home. The RCMP determined that Sam was a victim of homicide, and believes that Derek, age ten at the time, was responsible. At the time of the incident, Derek was living with his mother and was receiving services from Yorkton Tribal Council Child and Family Services Inc. (the Agency). In accordance with the *Youth Criminal Justice Act*, Derek was not charged with an offence as he was under the age of 12. Rather, *The Child and Family Services Act* states that a child under 12 who is suspected of committing a criminal offence may be considered to be in need of protection. Derek was determined to be in need of protection and was taken into care by the Agency. He remains in their care.

The purpose of this report is to determine whether these children received the services to which they were entitled

In conducting this investigation, we are not passing judgment on Derek's guilt or innocence. He will never be charged with an offence in relation to this incident. The purpose of this report is to determine whether these children received the services to which they were entitled and make recommendations to improve the capacity of child serving systems to ensure the rights of children are upheld. The lessons learned here are critical to guiding future case practice for other children with circumstances similar to those of Sam and Derek. Child serving systems must provide equal standards of care to *all* children in Saskatchewan, while promoting the best interests, safety and protection of the children they serve, if tragedies such as this are to be prevented.

Key elements of the report include:

- Sam received many supports from his school and MSS in the two years prior to his death. He was living with his mother when he was apprehended by MSS in June 2013. Sam's mother was experiencing mental health issues and MSS determined that Sam needed to be apprehended for his own safety.
- Our investigation found that some MSS policies and procedures were not followed respecting the services provided to Sam and his family. This resulted in MSS having less than complete information to make timely and accurate decisions for Sam's family and his care.
- In particular, MSS should have sought more timely assistance for Sam's mother at a crucial period in her life, and when they did apprehend Sam, they should have explored additional options to keep Sam with his family.
- Derek and his family were clients of the Agency and he was living with his mother on a First Nation at the time of Sam's death. He is a vulnerable child with complex needs that were not met. Derek was ten years old when he was diagnosed with Fetal Alcohol Syndrome, which is part of Fetal Alcohol Spectrum Disorder (FASD).
- The RCMP and his school had reported concerns to the Agency about Derek's needs, however these were not adequately followed up by the Agency.
- This investigation found the Agency failed to act when Derek required protection, and failed to provide services to address his complex needs.
- The Advocate recognizes that these children and their families faced challenges, and believes that they would have benefitted from better access to prevention and early intervention services.
- The Advocate recommends that the Government of Saskatchewan invest in well resourced early childhood development and poverty reduction strategies to advance the goals of its Child and Family Agenda.

These children and their families faced challenges and would have benefitted from better access to prevention and early intervention services

- The Advocate recommends a number of improvements to casework practices by child protection staff within MSS and the Agency. These include greater adherence to casework procedures and improved oversight by supervisors.
- MSS has Agreements with First Nations Agencies to provide child and family services to individuals living on First Nations that would otherwise be provided by MSS. MSS continues to be accountable for the safety and protection of all children requiring services under *The Child and Family Services Act*.
- The Advocate recommends that MSS strengthen its oversight of the Agency immediately. The Agency's services must meet provincial standards.
- The Advocate is asking that MSS and the Agency to work collaboratively and to report their progress on the recommendations made in this report to our office.
- The Advocate recommends that the Ministries of Social Services and Health develop a protocol to provide timely services to families and children who are in the child welfare system and experiencing mental health issues.
- The Advocate also recommends the Regina Qu'Appelle Health Region examine whether the criteria for initiating incident reviews of various types need to be adjusted, and that the Ministry of Health and Regional Health Authorities introduce an outreach program for children like Derek in rural and remote areas.

1.1 The Incident

On the evening of August 21, 2013, six year old "Sam" was reported missing in a rural community in Saskatchewan. After an extensive search by community members and an alert to the RCMP, Sam was found critically injured in a secluded area. He was taken to a local hospital by ambulance to be transported via STARS helicopter to a larger hospital. Unfortunately, Sam died just after midnight on August 22, 2013, before this transfer could take place. At the time of his death, Sam had been in the care of the Saskatchewan Ministry of Social Services (MSS) for two and a half months and was residing in a foster home.

Children under 12 who are suspected of a crime may be considered to be in need of protection

This case received national and international attention, in part because the RCMP determined the primary suspect to be another child, age ten at the time. For the purposes of this report, the second child is referred to as "Derek."

Children under 12 cannot be charged with a criminal offence, according to Canada's *Youth Criminal Justice Act*. In Saskatchewan, under *The Child and Family Services Act*, children under 12 who are suspected of such a crime may be considered to be in need of protection, particularly if it is determined that their parents are unable to provide for their needs. Derek was determined to be in need of protection and was taken into care by the Agency. He remains in their care.

Services to children must be provided equitably across the province

Derek was living with his mother at the time of the incident and he and his family were receiving child welfare services from Yorkton Tribal Council Child and Family Services Inc. (the Agency). The Government of Saskatchewan has an Agreement with this Agency to provide services.

As per our legislation, the names of the boys have been changed to protect their privacy, as well as that of other individuals involved in their lives.

1.2 Mandate of the Advocate for Children and Youth

The Advocate for Children and Youth (the Advocate) is an independent officer of the Legislative Assembly of Saskatchewan. The mandate of the Advocate is set out in *The Advocate for Children and Youth Act*, and consists of:

- advocating on behalf of children and youth receiving services from a provincial ministry, direct or delegated agency or publicly funded health entity;
- investigating any matter that comes to its attention concerning any services provided to children and youth by these bodies;
- providing public education to raise awareness of the rights, interests and well-being of children and youth; and
- working collaboratively with any ministry responsible for matters relating to the rights, interests and well-being of children and youth to provide advice for achieving and enhancing the objectives of young people in this province.

Our work is grounded in the *United Nations Convention on the Rights of the Child*,[1] an international human rights treaty that was ratified by Canada in 1991. The Advocate has distilled the rights and obligations put forward in the *Convention* into the *Saskatchewan Children and Youth First Principles*.[2] The Government of Saskatchewan adopted these principles in 2009.[3] These state that services to children must be provided equitably across the province, with the highest standard of health and education being available to them to help reach their full potential. Children should be free from all forms of physical, emotional and sexual harm. The rights and interests of the child must be paramount, with their needs at the centre of all planning about their care.

The Advocate also follows the *Touchstones of Hope for Indigenous Children, Youth and Families*[4] that ensure services provided to First Nations and Métis children recognize the child is shaped by his or her traditions, spirituality and social customs. These principles recognize the importance of First Nations people providing child and welfare services to their communities.

The Child and Family Services Act

The Ministry of Social Services Child and Family Services Division administers *The Child and Family Services Act*. The purpose of the *Act* is to promote the well-being of children in need of protection by offering services designed to support and preserve the family in the least disruptive manner. The *Act* provides the mandate to investigate reports of child abuse or neglect, and it encourages that services be provided to families in such a way so that children can remain safely in their homes wherever possible. When necessary, children may be removed from the family home when their parents are not able to care for them. The *Act* informs the policies followed by MSS and First Nations Agencies.[5]

1.3 Scope and Methodology

The Advocate investigated the periods during which services were provided to both boys and their families up to the date of Sam's passing on August 22, 2013. This report does not cover the complex issues surrounding Derek's care after that date. Derek will likely require health and social services for some time to come, and he could require ongoing advocacy from our office as per our mandate.

During our investigation, we reviewed all available documentation on both boys' child welfare files and interviewed more than fifty people, including parents, foster parents, social workers, school officials and health care providers who influenced the boys' lives. We examined the casework of MSS and the Agency, and looked at MSS's obligations to oversee the quality of Agency services. We also reviewed relevant information on the involvement of other child-serving systems, such as the Ministry of Health, the schools and the RCMP. In undertaking this review, we considered whether the services provided by MSS and the Agency fulfilled their obligations under *The Child and Family Services Act* (the *Act*). We also considered whether services to both boys adhered to the principles of children's rights.

MSS, the Agency, the Ministry of Health and the Regina Qu'Appelle Health Region were given the opportunity to review and provide comments on the facts outlined in this report under the principle of administrative fairness, as they had provided evidence. We thank them for their cooperation.

1. United Nations General Assembly, Convention on the Rights of the Child. 1989. Available from: //www.unicef.org/crc/

2. Children and Youth First Principles, Saskatchewan Advocate for Children and Youth. Available from: http://www.saskadvocate.ca/children-youth-first/children-youth-first-principles.

3. Government of Saskatchewan. Putting children first: province takes action on child welfare [Press release]. February 25, 2009. Available from: http://www.gov.sk.ca/news?newsId=308e1b59-17ef-47b0-98f1-086003a17fd0

4. Blackstock, C., Cross, T., George, J., Brown, I, & Formsma, J. Reconciliation in child welfare: Touchstones of Hope for Indigenous children, youth, and families. Ottawa, ON, Canada: First Nations Child & Family Caring Society of Canada / Portland, OR: National Indian Child Welfare Association, 2006. More information on the Saskatchewan Advocate for Children and Youth's adoption of these principles is available at: http://www.saskadvocate.ca/children-youth-first/touchstones-of-hope.

5. These policies are included in the Saskatchewan Ministry of Social Services' Family-Centred Services Manual, the Children's Services Manual and the Structured Decision Making® System for Child Protective Services. They are available from the Government of Saskatchewan's Publications Centre at: http://www.publications.gov.sk.ca/deplist.cfm?d=17&c=1047

2.1 Early Years

"Sam" was born a healthy baby in October 2006. He was the only child born to his parents, who lived together in rural Saskatchewan. Prior to Sam's birth, MSS received an expression of concern about the mental health and cognitive challenges of his mother and whether she could adequately care for him, as well as concern about disharmony between his mother and father. As a result, MSS staff met with Sam's parents following his birth and determined that he could safely remain in their care if they were provided with parenting support.

Sam was a shy and quiet child who liked to play with his remote control airplane and go to the park

A family services file was opened and MSS signed a Parental Services Agreement with both of Sam's parents stipulating that they participate in a parenting program. This program was provided in their home by a contracted parent aide for approximately four months. Sam's parents successfully completed the program and the family services file was closed in January 2007.

Parental Services Agreements

A Parental Services Agreement is a voluntary agreement signed between a child's parents and MSS reflecting their desire to work together in the best interests of the child. The Agreement outlines the reason for child and family services involvement and identifies the tasks and outcomes to be achieved by the parents and MSS staff. These agreements are typically 120 days in length and can be renewed or amended as necessary. If MSS staff believe a child requires protection, either or both parents will be asked to sign a Parental Services Agreement. If parents are unwilling to sign an agreement, MSS is required to make an application to court for a protection hearing, so a judge can determine whether the child is in need of protection.[6]

2.2 Sam Enters School

In September 2011, Sam began kindergarten. He was described to the Advocate as a somewhat shy and quiet child, who liked to play with his remote control airplane and go to the park. Sam enjoyed playing computer games and watching cartoons. Math and art class were his favourite subjects in school and he had a stuffed animal that he often carried with him.

Sam had little contact with community programming prior to entering school. Once in kindergarten, school staff determined that he had speech and learning delays. They also identified that he had needs related to inappropriate behaviour. The school provided services for Sam, including speech and language pathology, academic assistance and behaviour management. Sam's mother requested and received home visits from a school social worker to help her develop positive parenting skills. In February 2012, the school reported to MSS that there were concerns with domestic disharmony that may be harmful to Sam. As a result, MSS re-opened their family services file and met with Sam's mother to assess his safety.

After investigating the school's report, a Risk Assessment was required to identify risk factors that could potentially result in harm to Sam. This Assessment was not completed. Nevertheless, MSS asked Sam's mother to sign a Parental Services Agreement. She agreed to attend an outreach program to learn more about the impacts of domestic disharmony. Sam's father was not part of this Agreement. While MSS offered various supports so that Sam's mother could attend this program, she did not participate.

The family services file remained open for the next several months, but there was no further contact between MSS and Sam's family. In September 2012, MSS staff completed an Investigation Record related to the school's February report. Policy requires that this document, which summarizes the activities and conclusions of an investigation, be completed within 30 days of the investigation being assigned.[7] In this case, the Investigation Record was completed seven months later.

During this time, school staff contacted MSS with concerns that the conflict between Sam's parents was increasing and that he may have experienced physical harm. Despite the fact that there was an open family services file pertaining to similar issues, these additional concerns were not recorded in MSS files or acted on by MSS staff.

How does MSS determine children are safe?

MSS uses a tool called the Structured Decision Making® System for Child Protective Services (SDM®)[8] to improve child protection workers' abilities to assess if children are safe in their homes, if families require additional services to care for their children safely, or if children should be apprehended. This model was implemented in June 2012. Casework requirements for the initial stages of investigation and assessment under the SDM® model include:

1. an **Intake Assessment** to determine whether the circumstances of the report constitute a child protection concern under *The Child and Family Services Act*;
2. a **Safety Assessment** to identify safety threats and whether capacity exists to keep a child safe in the home during the period of investigation;
3. a **Risk Assessment** to determine the level of risk of future maltreatment and to guide the decision to close an investigation or provide post-investigation services;
4. a **Family Strengths and Needs Assessment** to identify the priority needs of the children and caregivers that will be addressed in the case plan.

2.3 Significant Family Issues Identified

In September 2012, Sam was admitted to a hospital for respiratory issues. Hospital staff reported concerns to MSS about negative interactions between Sam's parents while in the hospital. When Sam was discharged a few days later, his mother separated from his father and she and Sam moved to a shelter until she could find a new residence.

MSS investigated the hospital's report and assessed the family risk level as *high*. Risk factors included limited parenting skills, domestic disharmony, his mother's mental health and concerns about his father's use of alcohol. It was determined that Sam was safe in his mother's care, with supports from MSS.

Sam's mother signed another Parental Services Agreement, the third since his birth. She agreed to take steps to obtain sole custody of Sam and to meet with a contracted family support worker. This worker provided a one-to-one program to increase Sam's mother's understanding that negative interactions between parents can be harmful to their children. This Agreement also stated that supports to improve parenting skills would be provided to Sam's mother.

Again, Sam's father was not part of the Parental Services Agreement. Since he and Sam's mother were separated and lived apart, MSS thought he would no longer be playing an active role in Sam's life. However, in the months that followed, he spent most weekends with Sam and his mother.

There was good communication between Sam's old and new school regarding his needs, and he continued to receive support services

After a short stay in the shelter, Sam and his mother relocated to another town in rural Saskatchewan. Sam changed schools and continued in grade one. There was good communication between Sam's old and new school regarding his needs, and he continued to receive support services at his new school. In spite of this, Sam's behaviours and interactions with his peers continued to concern school staff. He was referred to an educational psychologist to determine whether or not he required a formalized assessment. This process was still underway.

Over the winter of 2012/2013, MSS worked with Sam's mother to address family issues and the school continued to address Sam's behaviour in the school setting. During this time, it became clear to MSS that Sam's father was actively involved in parenting him, even though he was not living in the home. Therefore, in January 2013, MSS signed a Parental Services Agreement with both parents. In addition to supports already in place for Sam's mother, his father agreed to complete an addictions assessment and to meet regularly with a psychologist.

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6. MSS, Family-Centred Services Manual, Ch. 5, Sec. 2
7. MSS, Family-Centred Services Manual, Ch. 3, Sec. 18
8. Children's Research Center, The Structured Decision Making® System for Child Protective Services, 2012

2.4 Services to Sam Intensify

At this point, MSS put services in place for Sam to address any needs he may have arising from disharmony in the home. These services were provided by the contracted family support worker already involved with his mother. MSS also took appropriate steps to communicate with Sam's school to gather information which could help them understand his needs.

Another Parental Services Agreement was signed with both parents in April 2013. By this time, it had become apparent that Sam's increasing behavioural challenges required more intensive services and he was referred to a child psychologist. The child psychologist reportedly advised MSS that quality parenting is the most important factor in the well-being of young children and that MSS must ensure Sam's mother receive adequate supports to parent Sam effectively.

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2.5 Inadequate Service Response

Although parenting support for Sam's mother was referenced in Parental Services Agreements, additional parenting supports were not a focus of the programming being provided. MSS advised the Advocate they did not want to overwhelm Sam's mother with too much information. Instead, services provided to her dealt primarily with understanding domestic disharmony and the effects this could have on Sam.

In addition, Sam's mother's mental health issues were not addressed, in spite of having been identified by MSS in numerous assessments on the family. Parenting supports were not included in the plan for Sam's father, nor was he referred for an addictions assessment as required by the January 2013 Parental Services Agreement.

From January to April 2013, MSS received three reports of potential physical harm to Sam. The first was reported by the RCMP, who advised MSS that they had received and investigated an allegation that was found to be unsubstantiated. MSS decided not to conduct their own investigation into this matter. However, no rationale for this decision was provided on their Intake Assessment.

The second report involved bruising on Sam that was not brought to MSS's attention until three months after it was observed. MSS decided, in accordance with policy,[9] not to investigate this matter on the basis that it was "historical," did not represent a pattern of abuse, an alternative explanation had been provided for the bruising and there were already supports being provided to the family.

The third concern of potential physical harm was reported to MSS less than one month later. MSS received a photograph of current marks on Sam's body that were alleged to be bruises. In violation of policy, this report was not documented in the MSS file or referred to police. Moreover, there was no record of Sam being seen by MSS staff or examined by a physician.

2.6 Casework Accountability Lacking

Parental Services Agreements are meant to be short term agreements and do not require supervisor approval. When MSS remains involved with a family for 90 days, a more comprehensive Assessment and Case Plan is required. The Assessment and Case Plan is reviewed and updated every 120 days thereafter.[10] Assessments and Case Plans require approval of an MSS supervisor, which provides an additional level of accountability. However, MSS staff did not complete an Assessment and Case Plan for Sam's family until after he passed away. By that time, MSS had been working with the family for a year and a half. The reason for this was described to the Advocate as being due to staff not having enough time to complete all required paperwork. Instead, contrary to policy, MSS only worked with the family through Parental Services Agreements.

Had an Assessment and Case Plan been completed and reviewed, the supervisor might have identified issues that were not being addressed.

2.7 Decision to Apprehend Sam

On June 6, 2013, during a scheduled session with the family support worker, Sam's mother disclosed that she felt overwhelmed and was considering suicide. Sam was living with his mother at that time, although his father was still a part of his life. Sam's mother's

disclosure was reported to MSS who promptly apprehended Sam. MSS did not take immediate steps to have her mental health assessed.

MSS did not complete a formal assessment of Sam's father's ability to care for him safely immediately upon apprehension from his mother. Furthermore, a Risk Assessment had not been completed on Sam's father's household prior to apprehension, despite MSS being aware that Sam was spending time there. Although Sam's father had been included as a secondary caregiver on Risk Assessments completed for his mother's household, SDM® policy states that only one household can be assessed at a time.[11] MSS documentation later cited initial concerns of domestic disharmony as the reason why Sam's father could not care for him. However, a Risk Assessment including his father as a secondary caregiver was completed only three weeks earlier and did not identify this as a threat to Sam's safety.

2.8 Exploring Extended Family Placements

Following his apprehension, Sam was initially placed in the care of extended family members. However, they advised MSS they would not be able to care for him over the long term. Additional supports were offered to assist with maintaining the placement, but this was not possible.

MSS appropriately explored other extended family within Saskatchewan who may have been able to care for Sam, but none were available. Family residing out of province were identified as potential caregivers for Sam, but MSS determined the distance would be a barrier to family visits. MSS works to reunify children with their families whenever possible and family visits are integral to this process. Accordingly, the search for a foster home began.

2.9 Efforts Toward Reunification

Reunification was identified as the goal for Sam and MSS took steps towards this goal.

A Parental Services Agreement was signed with both parents on June 17, 2013. MSS agreed to refer Sam's mother for mental health services and to refer both parents for a Parenting Capacity Assessment. These Assessments are comprehensive evaluations of parents' ability to care for their children in the face of various challenges they may be experiencing. Sam had been in care for one month before MSS initiated these referrals. Furthermore, MSS did not follow up with the psychologist who was requested to do the Parenting Capacity Assessment by the time of Sam's death a month and a half after the referral was made. The psychologist reported to the Advocate that MSS had committed to forwarding documentation to assist him in beginning this Assessment. He said he did not receive this information and, therefore, assumed an Assessment was no longer required.

On July 11, 2013, MSS asked Sam's parents to sign an Agreement for Residential Services under Section 9 of *The Child and Family Services Act* (Section 9 Agreement). These agreements allow for parents to voluntarily place their child in the care of the Minister of Social Services when they are unable to meet the child's needs. When it is determined that a child must enter care, MSS prefers to work through these agreements rather than going to court. Policy states that Section 9 Agreements are only to be used when parental issues can be resolved quickly and the case plan is for the child to be returned home. MSS told the Advocate they did not immediately enter into this Agreement when they removed Sam, in part, because they were waiting for legal advice to confirm that it was sufficient for only one parent to sign. Sam's mother signed the Agreement, but Sam's father declined.

Reunification was identified as the goal for Sam and MSS took steps towards this goal

2.10 Foster Home Placements

Sam was transferred to a foster home on July 11, 2013. At first, things appeared to go well for him. However, approximately two weeks after he was in this home, Sam displayed concerning behaviours following a visit with his parents. Sam's foster mother told the Advocate she was concerned with how Sam was interacting with other children in her home after this visit.

9. MSS, Family-Centred Services Manual, Ch. 3, Sec. 2

10. MSS, Family-Centred Services Manual, Ch. 4

11. Children's Research Centre, The Structured Decision Making® System for Child Protective Services, 2012: 65

While MSS offered the foster parent support to maintain Sam's placement, she indicated that his needs were too complex for her to handle. She requested that MSS move Sam immediately. This foster mother told the Advocate that she was not provided with any detailed written information about Sam's needs before his placement. She said she only received verbal information from a worker.

On August 1, 2013, Sam was transferred to a second foster home, where he remained until his death. This was Sam's third placement in two months. This second foster parent also reported that she did not receive written information about Sam's needs.

Sam liked to ride on the farm equipment with his foster father and go on excursions with his foster mother

Sam seemed to enjoy living on the foster family's farm. He liked to ride on the farm equipment with his foster father. It was summertime and he and his foster mother went out on excursions in the area where they lived.

Sam was in care for two and a half months. At that time, policy required that a Child Assessment and Development Plan be completed when a child was in care for 30 days.[12] These Plans serve as a record of a child's life in out-of-home care, guide case planning, assist potential caregivers in deciding whether they have the capacity to meet the child's needs, and prompt MSS to review and assess important areas of the child's development. They also provide space to record plans for family contact. A Child Assessment and Development Plan was not completed for Sam until after his death.

Although a family visitation schedule was not found in MSS's file, Sam's visits with his parents were scheduled on a weekly basis. Five family visits were documented and three were cancelled. One cancellation was due to Sam being ill and another out of concern with his behaviour following a previous visit. The last family visit scheduled before Sam's death was cancelled because the visiting room at the MSS office was booked. The decision to cancel the visit was not discussed with a supervisor and alternative locations were not explored.

2.11 The Evening of August 21, 2013

On the evening of August 21, 2013, Sam's foster mother took him to a recreation centre in a nearby community. She had taken Sam on various outings before, including for ice cream in this particular community, and had no reason to be concerned about this trip.

She originally intended to arrange for a babysitter to stay with Sam that evening. However, her husband offered to pick Sam up at approximately 8:30 p.m., after he finished his chores on the farm, so she took him along with her. It was reported to the Advocate that Sam was at her side all evening until shortly before her husband was due to arrive. She gave Sam some money to purchase a treat at the canteen inside the recreation centre. It was summertime, and the sun was still up. The Advocate was advised that when Sam did not return approximately 15 minutes later, his foster mother began looking for him.

When she could not find Sam right away, a number of community members joined in the search. Shortly after, the RCMP were called. Sam's foster father arrived to help with the search. Approximately 90 minutes after he went missing, Sam was found seriously injured in a secluded area nearby. Emergency medical services were called to the scene and Sam was transported to the local hospital. A STARS helicopter was called to take Sam to a larger hospital for more intensive care.

Sam could not be stabilized and he died shortly after midnight, before the STARS transfer could take place. A forensic pathologist later determined the cause of Sam's death was blunt force trauma.

At the time this report was written, MSS continued to provide resources and services to Sam's parents to support them in their grief.

12. MSS, Children's Services Manual, Sec. 2.5

3. ADVOCATE'S FINDINGS RESPECTING SAM

Our investigation found that Sam was a vulnerable child, whose family faced many challenges that could put him at risk. While MSS provided services to Sam's family when he was an infant, during his early years he and his family had little interaction with prevention and early intervention services. Sam and his family would have benefitted from these services before he reached kindergarten.

Once he entered the school system, trained professionals were able to identify issues related to Sam's speech, academics and behaviour, and began to address them. The school also identified and reported child protection concerns to MSS so that MSS could begin to provide child and family services. Sam was five years old by the time these issues came to light. Had Sam and his family been involved in early childhood development programming, these issues may have been identified and addressed earlier, before they became more entrenched. Instead, Sam and his parents were on a negative trajectory that was firmly established by the time they came to the attention of MSS.

Our investigation found that, once these issues were identified, Sam was provided with relatively comprehensive services through his school and programming and counseling services arranged by MSS. When these interventions were deemed insufficient to meet his behavioural needs, MSS appropriately adapted the case plan to refer him to a private child psychologist who could better assist him. These outside services were provided to Sam in a timely manner and according to MSS procedures.

Our investigation also identified a number of gaps in services to Sam's parents. Had all appropriate services been provided, this may have made a difference in his parents' ability to safely care for him. Furthermore, the Advocate has concerns with MSS staff not investigating allegations of bruising that came to their attention, and the lack of timeliness in completing case planning forms. Sam's father was not immediately assessed as a potential caregiver and efforts to reunite Sam with either of his parents were delayed. We found a lack of documentation and insufficient supervision on Sam's file as well. Perhaps most important, Sam's mother's mental health issues were not explored in a timely manner.

Under the *Children and Youth First Principles*, children are to be treated as the primary client, at the centre of all child serving systems. As emphasized by the child psychologist, providing services to all parents who need to improve parenting skills is part of this. As such, more intensive parenting support to both of Sam's parents would have been in Sam's best interest. It appeared that some of MSS's actions relegated Sam and his needs to the background, rather than placing them at the forefront.

In particular, our investigation noted these concerns:

3.1 Quality of Investigation

Finding #1: *Child protection reports were not consistently documented and investigated. Some documentation was missing or not completed within policy timelines.*

Three of the child protection concerns documented by MSS were not investigated within timelines set out in policy.[13] This ranged from investigations beginning four days to nearly one month late. Some file documents were completed outside of policy timelines.

More intensive parenting support to both of Sam's parents would have been in Sam's best interest

Section 11 of *The Child and Family Services Act* defines a child to be in need of protection when physical or mental violence, injury or abuse is suspected.[14] On more than one occasion, MSS received reports that Sam may be at risk of physical abuse, but failed to investigate. MSS made a decision to screen out one such report, which complied with policy. However, it is especially concerning to the Advocate that MSS failed to investigate when a third report of alleged physical abuse was made within a three month timeframe, which may have shown a developing pattern. In the third report, MSS received a photograph of alleged bruising on Sam less than one month after a report of the same nature. In spite of this, Sam was not visually examined by MSS or seen by a physician and the matter was not brought to the attention of police. Investigation policy, as well as the Provincial Child Abuse Protocol,[15] requires these steps.

13. MSS, Family-Centred Services Manual, Ch. 3, Sec. 8 & 9; Children's Research Centre, 2012: 30

14. The Child and Family Services Act, Sec. 11

15. Government of Saskatchewan. Provincial Child Abuse Protocol, 2006. Available at: http://socialservices.gov.sk.ca/child-abuse-protocol.pdf

As a proper investigation into these concerns did not occur, it can never be determined whether or not Sam was at risk of physical harm. At the very least, these complaints would have been an opportunity for MSS to provide greater supports to Sam and his family.

3.2 Quality of Case Planning

Finding #2: *The case plan for the family was not consistent with the needs identified in assessment tools. It failed to offer adequate support to Sam's parents to make the changes that would ensure his safety and well-being.*

MSS never formally offered parenting supports to Sam's father, and these services were not consistently provided to Sam's mother

It is in children's best interests to live with adults who are able to nurture and support them, so they can develop to their full potential. Parents sometimes need support in order to provide a safe and nurturing family environment. This often includes services to build the parents' understanding of child development and their ability to interact with their child in ways that promote well being. *The Child and Family Services Act* recognizes this, and outlines government's responsibility "to promote the well-being of children in need of protection by offering, wherever appropriate, services that are designed to maintain, support and preserve the family in the least disruptive manner."[16]

Some services were put in place for Sam's parents to address personal issues that might have put him at risk. However, MSS missed opportunities to strengthen Sam's family before they apprehended him from his mother's care. MSS policy states that the needs of the family as identified in the Family Strengths and Needs Assessments and Risk Assessments are to be used as the foundation for the case plan.[17] There were clear gaps between the identified needs of Sam's parents and the services provided by MSS.

MSS repeatedly identified the emotional instability of Sam's mother as a protection concern, yet they did not formalize mental health services as part of the case plan until after Sam was apprehended. Similarly, there were numerous references on the MSS file related to concerns about Sam's father's use of alcohol, but a referral for an addictions assessment was not made and this requirement was not included in Parental Services Agreements signed after January 2013. MSS never formally offered parenting supports to Sam's father, and these services were not consistently provided to Sam's mother, even though they were included in Parental Services Agreements.

Case conferences are a tool that can be used by MSS to facilitate a meeting between a family and any service providers that may be working with them. The goal of case conferences is to agree upon outcomes for change and to ensure that services are coordinated to meet these outcomes.[18] MSS did not engage in case conferencing with Sam's family and service providers at any point in their involvement, thereby missing the opportunity to benefit from this type of dialogue and joint planning. For example, these meetings could have highlighted the importance of quality parenting as expressed by Sam's child psychologist.

Finding #3: *There was no documented case planning for Sam following his apprehension.*

Sam's service needs were captured in Parental Services Agreements prior to his apprehension. However, MSS did not follow policy requirements to record this information or engage in formal case planning for Sam after his apprehension. A Child Assessment and Development Plan was not completed until after Sam's death, despite being required 30 days after a child comes into care. At the time of his death, Sam had been in care for 76 days. In addition, neither of Sam's foster parents were provided with written information about his background or current needs.[19]

The lack of formal case planning for Sam at required intervals increased the potential for MSS to lose sight of his best interests when making decisions about his

The lack of formal case planning for Sam at required intervals increased the potential for MSS to lose sight of his best interests

life in out of home care. Furthermore, foster parents provide a necessary service within the child welfare system and must be provided with all the tools they need to best care for the children placed in their homes. Policy must be followed to ensure that children are always treated as the primary client. For Sam, this would have included placing a higher priority on recording and communicating his needs.

3.3 Supervision

Finding #4: *Supervisory oversight to ensure proper planning and services to Sam's family was lacking.*

It was reported to the Advocate that there was frequent consultation between the child protection worker and supervisor involved in Sam's case. Documentation also indicated that the supervisor was consulted at key decision-making points. However, formal casework supervision did not meet policy standards. Supervisors, according to policy, are expected to review each case with a child protection worker every four months.[20] A comprehensive review of Sam's case occurred once in the year and a half that MSS was involved with him and his family.

A timely Assessment and Case Plan may have effectively addressed the lack of services provided to Sam's mother and father related to mental health, addictions assessment, and parenting. Rather than completing Assessment and Case Plans within policy timelines, MSS worked with the family solely through Parental Services Agreements.

While Assessment and Case Plans are routinely reviewed and approved by supervisors, Parental Services Agreements are not. A Parental Services Agreement does not provide enough information for a supervisor to make an informed decision about the appropriateness of services provided. The child protection supervisor reported to the Advocate that she was not aware that aspects of the Parental Services Agreements were not being addressed.

A completed Assessment and Case Plan and the supervision that it involves, would have been a critical opportunity to evaluate the effectiveness of the supports and services Sam and his family were receiving, and to modify these services if needed. For instance, Sam's mother received services for approximately nine months to help her understand how domestic disharmony affects children. Though MSS noted she had made little progress, the intervention to address this risk factor did not change or intensify.

3.4 Assessment of Sam's Father

Finding #5: *There was no formal assessment of whether Sam's father could safely parent him at the time of apprehension.*

MSS apprehended Sam from his mother's care based on her threat of suicide. The file also identified the pre-existing issues and concerns with Sam's mother and father as factors in the decision to apprehend. However, these prior concerns did not meet MSS's threshold for apprehension. It is probable that if Sam's mother had not expressed thoughts of suicide, Sam likely would have remained in her care.

MSS should have formally assessed whether Sam's father could safely care for him in a more timely manner. While MSS was scheduling a Parenting Capacity Assessment to determine whether Sam could be returned to either parent, SDM® procedures provide assessment tools that should have been utilized first. For example, a separate Risk Assessment on Sam's father's household prior to apprehension could have helped to inform this decision. There is no documentation that this possibility was considered, assessed or discussed with Sam's father when MSS determined Sam was unsafe in his mother's care. There was no custody order in place that would have prevented this arrangement.

A timely Assessment and Case Plan may have effectively addressed the lack of services provided to Sam's mother and father

Weeks later, MSS documented in Sam's file that his father was not an option because of initial concerns related to domestic violence. However, MSS was

16. The Child and Family Services Act, Sec. 3

17. Children's Research Centre, The Structured Decision Making® System for Child Protective Services, 2012: 88

18. MSS, Family-Centred Services Manual, Ch. 5, Sec. 3

19. MSS, Children's Services Manual, Sec. 2.4

20. MSS, Family-Centred Services Manual, Ch. 9, Sec.2

aware that Sam was spending a great deal of time with his father, yet these concerns had not met the threshold for apprehension prior to the suicide threat. A Risk Assessment, which included Sam's father as a secondary caregiver, had been completed only three weeks earlier indicating there had been no domestic violence in the past year.

MSS policy recognizes that separation from a parent can be harmful to a child and, except in cases where the child is in immediate danger of abuse, this risk must be weighed against the hazards of leaving the child in a less than satisfactory home.

It would have been in Sam's best interests to have his mother's mental health assessed immediately after she expressed thoughts of suicide

We must stress here that we are not in a position to determine whether or not Sam would have been safe in his father's care. However, in order to ensure that Sam's best interests were the primary focus, formally assessing and exploring all family alternatives should have been done at the time of apprehension, or as soon as possible thereafter.

3.5 Timeliness of Assessment and Services

Finding #6: *All available services were not engaged to obtain an immediate assessment of the risk Sam's mother posed to Sam or herself.*

It would have been in Sam's best interests to have his mother's mental health assessed immediately after she expressed thoughts of suicide. This would have clarified whether the threat was imminent and if it was necessary for Sam to be out of her care while awaiting the results of a Parenting Capacity Assessment.

Saskatchewan's mental health system provides immediate telephone screening to determine a person's level of risk to themselves or others and the urgency with which they require mental health treatment. If screened as high risk, immediate psychiatric assessment is provided. If risk is determined to be low or moderate, individuals may be placed on a waitlist for assessment and treatment. Another option would have been to take Sam's mother directly to an emergency department for such an assessment. This could have resulted in an immediate response. MSS did not take these steps to expedite a mental health assessment for Sam's mother.

Sam's contact with his parents was not consistent and did not always take place in the home, as required by policy

3.6 Family Contact Standards

Finding #7: Family contact standards were not consistently met with Sam or his parents during MSS's involvement with the family.

MSS policy sets out specific requirements for contact with families receiving services whose children remain in the home. The frequency of contact is based on the family's assessed level of risk. In this case, contact standards were not consistently met either with Sam or his parents prior to his apprehension.

Throughout their involvement with MSS, the family's risk level was determined to be either *high* or *very high*. MSS policy stipulates that a high risk rating requires three face-to-face contacts per month, at least one of which must be with the child separate from his parents. A very high risk rating increases the requirement to four face-to-face contacts per month.[21] MSS contact with the family was inconsistent and there were periods of time where Sam was not seen by a worker, either in person or separate from his parents.

MSS policy also sets minimum contact standards to be met with children in care and their parents when the goal is family reunification.[22] Sam was taken into care at the beginning of June 2013. Contact standards were met with Sam while he was in care. However, contact with his parents was not consistent and did not always take place in the home, as required by policy.

Parents are not empowered to be in control of their progress towards reunification when they have no control over referral times and waitlists for the services they require

Regular contact with families and children in care is an important way to monitor parents' progress and children's well-being, determine if changes to the case plan are necessary and to assess the potential for reunification.

3.7 Reunification Efforts

Finding #8: *Progress to reunify the family was hindered by the lack of timely referrals to outside services and by cancelled visits.*

MSS policy is based on a "family-centered philosophy" that puts priority on keeping families together. When children must be apprehended, family reunification becomes the primary goal whenever possible. MSS states that their approach to reunification "leave[s] the outcome in the hands of the parents, who are fully informed and explicitly empowered to make choices by their own actions and abilities".[23]

In Sam's case, MSS took important steps towards the goal of reunification. A Parental Services Agreement was signed with Sam's parents and referrals were made for outside services to assess parenting capacities. However, more timely steps could have been taken to determine whether reunification was possible.

Resources could have been engaged more quickly to assess Sam's mother's emotional stability at the time of apprehension. MSS did not refer Sam's mother for mental health services until over one month after his apprehension. Once she was screened by provincial mental health, Sam's mother was placed on a long waitlist for ongoing services. MSS could have contracted private mental health services to provide her with clinical treatment sooner.

Similarly, Sam had been in care for one month by the time MSS made a referral to a psychologist for his parents to receive a Parenting Capacity Assessment. Furthermore, MSS did not take steps to clarify why they did not hear back from the psychologist, nor did they seek out alternative resources.

Parents are not empowered to be in control of their progress towards reunification when they have no control over referral times and waitlists for the services they require. MSS policy does not include standard timelines for making referrals once a need has been identified. However, *The Child and Family Services Act* requires that any person responsible for determining the best interests of a child take into account the effect on the child of delays in making decisions.[24] MSS cannot control the timelines of external services providers. However, by ensuring referrals are timely, they can minimize the time children are required to spend in out-of-home care without a permanent plan.

The cancellation of visits can also hinder the reunification process. Visits not only maintain a family connection, but provide the opportunity for MSS to assess parents' progress with a case plan. Three of Sam's visits with his parents were cancelled, some of which could have either been rescheduled or arranged at alternate locations.

21. Children's Research Centre, The Structured Decision Making® System for Child Protective Services, 2012: 67

22. Children's Research Centre, The Structured Decision Making® System for Child Protective Services, 2012: 68

23. MSS, Family-Centred Services Manual, Ch. 7 Sec. 8: 37

24. The Child and Family Services Act, Sec. 4(h)

4.1 Early Years

"Derek" is the youngest of six children. There were periods in his life when his parents lived together and others when they lived apart. Derek's father took a major role in caring for the children. However, there were occasions that his father was absent and Derek's mother took over care of the children.

When Derek was nine years old, his mother disclosed to their doctor that she used alcohol during her pregnancy with Derek. This led to an assessment which determined in 2013 that Derek had Fetal Alcohol Syndrome. This condition likely affected his life in significant ways while he was growing up.

Derek was described to the Advocate as being "bright and joyful." We were told he loves to play outside with his siblings, go on adventures with his pet dogs, play video games, draw and play with toy cars. His favourite subjects in school are math and reading. Derek was also described as a vulnerable child who wants to fit in and have friends.

Described as "bright and joyful," Derek loved to play outside with his siblings, play video games and draw

Role of a First Nations Child and Family Services Agency

The Minister of Social Services has Agreements with First Nations Agencies to provide child and family services to First Nations individuals living on reserve. MSS continues to be accountable for the safety and protection of all children requiring services under *The Child and Family Services Act*. These agencies are obligated to meet the same standards of service provided to children and families by MSS. Agencies can also create their own operating procedures and protocols if they wish to expand on these standards. However, the Agency providing services to Derek and his family chose to follow the provincial policies.

Yorkton Tribal Council Child and Family Services Inc. serves many First Nations communities, with a central office and sub-offices on various First Nations.

4.2 Initial Agency Involvement

Child welfare services in the community where Derek and his family lived are under the jurisdiction of Yorkton Tribal Council Child and Family Services Inc. (the Agency).

The first documented contact with Derek's family by the Agency was in November 2008, when they received a report from a concerned community member regarding the lack of provision of basic needs to the children in Derek's family. At that time, there were four children in the home under the age of 14. These concerns were documented by the Agency in an Intake Report. This report was assigned for investigation. Policy required an investigation to be initiated within five days.[25] However, the investigation did not begin until three months later.

The Agency spoke with Derek's mother in March 2009. The Agency file indicates she was "warned" that if a second child protection report were to be received on the family, she and Derek's father would be required to sign a Parental Services Agreement to receive support services. She was also told that should a third concern be reported, the children would be apprehended. This was described by Agency staff as a "three strikes rule" that was practiced by the Agency, but not found in policy. Child welfare policy requires that the level of risk in a situation like this be continually assessed and children are only to be apprehended if their safety cannot be guaranteed in the home.

After speaking with Derek's mother in March 2009, the Agency determined that the file should be closed. They believed there was reasonable evidence to show the children's needs could be met without further involvement by the Agency. However, documentation required to conclude an investigation was not completed within policy timelines.

A Risk Assessment and an Investigation Record related to this incident were required by policy to be completed within 15 and 30 days, respectively, and before a matter is officially closed.[26] These documents were not completed until August 2009 – nine months after the Agency became aware of the concern, and five months after the file was closed. These documents indicated that the allegation was unsubstantiated and the children were not in need of protection. However, the overall risk level to the children was assessed as being *high*. A high risk rating does not support closure of the file.

By this time, another concern regarding supervision of Derek and his siblings had been reported to the

Agency and a separate investigation file was opened. However, it again took three months for the Agency to have documented contact with the family. As a result of this delay, the Agency completed a second Risk Assessment and Investigation Record within a week of the first. Risk to the children continued to be assessed as high. Risk factors included limited parenting skills and concerns with both parents' use of alcohol. A Parental Services Agreement was signed with Derek's mother in August 2009. Derek's father was not made a part of this Agreement, in spite of the fact that his mother was not living in the family home at the time and his father had sole care of the children. In this Agreement, Derek's mother agreed to take steps to address concerns with her use of alcohol and to meet with a family services worker on an ongoing basis. Supports to improve parenting skills were not included in this Agreement.

4.3 Reports from the School

Meanwhile, in March 2009, Derek's school sent a letter to the Agency expressing concern that he was exhibiting inappropriate behaviour at school and in the community. The school felt this could be an indication that Derek, himself, had experienced harm. The school requested the Agency's assistance in investigating these concerns. The Agency promptly assessed this report and determined the matter required investigation. Supervisory direction was provided for an Agency investigator to alert the RCMP. However, the Advocate could not find documentation to indicate that this matter was actually investigated by the Agency, or that the RCMP was notified of the report. There was no indication that the next Agency investigator who would later complete the Parental Services Agreement in August 2009 was made aware of the school's concerns about Derek and his needs.

On October 16, 2009, Derek's school sent a second letter to the Agency, with a copy to the RCMP, again reporting inappropriate behaviours by Derek at school and in the community. The school's letter indicated they had not received a response from the Agency after their first letter in March 2009.

This second report from the school was received by the Agency, and a supervisor provided direction to contact the RCMP for more information. Although this report would have met the criteria for immediate investigation, Agency action was delayed. In November 2009, the Agency accompanied Derek and his mother to an interview with the RCMP. Derek made no disclosures to indicate that he had been harmed. Agency records did not include reference to this interview and provided no indication that any follow-up occurred in this matter. Required documentation, such as a Risk Assessment or Investigation Record, was not found.

4.4 Disconnect Between Investigations and Family Services

Derek's mother returned to the family home and, over the fall of 2009 and spring of 2010, an Agency family services worker met with her to assist her in taking the steps laid out in the Parental Services Agreement. This staff member did not work directly with Derek's father, as he had not signed the Parental Services Agreement. The children in the home were not documented to have been seen during this period. The family services worker reported being unaware of reports to the Agency from Derek's school that had been received during her involvement with the family.

> The family services worker reported she was unaware of reports sent from Derek's school to the Agency

Likewise, the Agency investigator involved with the family in October and November 2009 reported being unaware that a family services worker was meeting with Derek's mother. An Assessment and Case Plan was completed in March 2010, indicating that the family services file would be closed even though the conditions in the Parental Services Agreement had not been met. This document was completed 16 months after the corresponding child protection report had been received, therefore failing to meet the 90 day timeframe required by policy.[27]

4.5 Lack of Follow-up of Mental Health Concerns

There was no further documented involvement between the Agency and Derek's family over the next year, nor were there any major incidents documented by the school. However, the school continued to be concerned with Derek's well-being. School officials reported to the Advocate that they had made a referral for Derek to receive mental health services through his First Nation's band in late 2009.

25. MSS, Family-Centred Services Manual, Ch. 3, Sec. 9

26. MSS, Family-Centred Services Manual, Ch. 3, Sec. 18

27. MSS, Family-Centred Services Manual, Ch. 4

It appears that a mental health therapist began working with Derek shortly after this referral was made. Although there is indication that the school, the Agency, and the RCMP believed mental health services were being provided to Derek on a regular basis, the mental health therapist advised the Advocate that her interactions with Derek were infrequent.

In 2009, the school also arranged for Derek to have a speech and language assessment. His language skills were found to be below average. In March 2010, Derek was referred for a Psycho-Educational Assessment to further assess his delays in language and social skills, as well as his inappropriate behaviours. This assessment concluded Derek had mental health needs that required additional psychological services. The mental health therapist told the Advocate that she was not made aware of this assessment or these recommendations. The Agency was also unaware of this assessment until after the incident of August 21, 2013.

A fundamental lack of communication delayed important services for Derek

This fundamental lack of communication delayed important services for Derek.

4.6 Serious Occurrence - May 2011

In May 2011, the RCMP suspected Derek, then age eight and a half, and another boy were involved in breaking into a private residence, in which property was damaged and a pregnant dog and her unborn pups were killed. Due to his age, the RCMP was unable to charge Derek with an offence. The RCMP reported this incident to the Agency and expressed concerns over the other matters regarding Derek that had been brought to the Agency's attention earlier, but had not been acted on.

While the RCMP suspected Derek of being involved in this incident, they did not interview him and turned the matter over to the Agency.

Our investigation found the Agency file respecting the RCMP's reported concerns was incomplete. For example, there was no indication on the file that the matter was reviewed by a supervisor at the time. However, an Agency investigator made a home visit on June 1, 2011, and found there were no adults present to supervise the children that were at home. The Agency investigator then went to the school, where staff reiterated concerns about Derek's inappropriate behaviours.

Suspicion of criminal action – a child in need of protection

Section 11 of *The Child and Family Services Act* defines situations in which a child would be found to be in need of protection. Children under the age of 12 who are believed to have committed an offence under the *Criminal Code of Canada* cannot be held criminally responsible, but can be seen as requiring protection from child welfare services in cases where this cannot be provided by a parent.

11. A child is in need of protection where:

(c) The child is less than 12 years of age and:

(i) there are reasonable and probable grounds to believe that:

(A) the child has committed an act that, if the child were 12 years of age or more, would constitute an offence under the *Criminal Code*, the *Narcotic Control Act* (Canada) or Part III or Part IV of the *Food and Drug Act* (Canada); and

(B) family services are necessary to prevent a recurrence; and

(ii) the child's parent is unable or unwilling to provide for the child's needs.

These allegations of violence should have triggered more urgent action by the Agency. Instead, the first contact with Derek's parents documented by the Agency did not occur until June 28, 2011, nearly two months after the incident. The Agency spoke with Derek's father, but there is no record that Derek was interviewed regarding this serious incident.

By this time, although there had been five child protection reports sent to the Agency about Derek, he had yet to be interviewed by the Agency.

According to *The Child and Family Services Act*, a child could be in need of protection when there are reasonable and probable grounds that he or she has committed an act that would be considered a criminal act if committed by someone aged 12 or older.[78] The policy in effect at that time identified this incident as

one which required immediate assessment of the needs of Derek and his family.[29] This did not occur.

The Agency did not have further contact with Derek's family until August 9, 2011, at which time Derek's father advised that he again was solely responsible for the care of the children. There was no further follow-up documented by the Agency. RCMP file material provided to the Advocate indicated they were told that an Agency staff member spoke with Derek on November 1, 2011. However, this was not documented in the Agency file. The required Risk Assessment and Investigation Record were never completed.

This serious incident of alleged animal abuse was a clear opportunity for the Agency to intervene to help Derek and his family, but it was overlooked.

Mental health indicators

Extensive research has identified that animal abuse is an indicator that can be used to help identify youth who may commit violent acts against other people in the future.[30] Since 1987, the *Diagnostic and Statistical Manual of Mental Disorders* has included physical cruelty to animals as one of the symptoms of Conduct Disorder, behaviour that either violates the rights of others, or breaks major societal norms.[31]

4.7 Diagnosis of Fetal Alcohol Syndrome

In April 2012, Derek was referred by his family physician to a child psychiatrist. Based on an interview with his mother and an examination of Derek, the psychiatrist referred Derek for a full Fetal Alcohol Spectrum Disorder (FASD) assessment by Child and Youth Services, part of the Regina Qu'Appelle Health Region. The psychiatrist also prescribed medication to control Derek's symptoms of hyperactivity.

The process of assessing Derek for FASD began four months later, when he was nine years old and took place over a number of months. In March 2013, the assessment team determined that Derek had Fetal Alcohol Syndrome, part of the Fetal Alcohol Spectrum Disorder. The assessment found that he had mild cognitive and language delays. Derek's medical and psychological assessment team determined that he would require a high degree of supervision indefinitely and that his parents would need enhanced supports to be able to provide for Derek's needs.

4.8 Lack of Follow-up on Fetal Alcohol Syndrome Diagnosis

Through the FASD assessment process, it was recommended that a school psychologist review the findings of the assessment so they could be incorporated into Derek's academic plan. It was also recommended that Derek's mother would benefit from respite services and should connect with the FASD Support Network of Saskatchewan, which is a community-based, parent-led provincial network that could provide her with information and support. Unfortunately, these important connections were not made. The mental health therapist who had been intermittently involved with Derek and his family advised the Advocate that she was not aware of the Fetal Alcohol Syndrome diagnosis or its recommendations. Furthermore, the Agency did not receive this documentation until after Sam's death.

Derek's medical and psychological assessment team determined that he would require a high degree of supervision indefinitely and that his parents would need enhanced supports to provide for his needs

This was a crucial point in Derek's life. He was already ten years old by the time he had been found to have Fetal Alcohol Syndrome. There were few resources available in his rural community. Access to early childhood intervention services, even before Derek entered school, may have been useful in identifying his significant needs and providing his family with necessary supports much earlier in his life. Once this diagnosis was made, a lack of integrated case management resulted in his family being left without the assistance they required to access any services that may have been available in urban areas.

28. The Child and Family Services Act, Sec. 11

29. MSS, Family-Centred Services Manual, Ch. 3 Sec. 8

30. Ascione, F. Animal Abuse and Youth Violence. Juvenile Justice Bulletin. Office of Justice Programs Office of Juvenile Justice and Delinquency Prevention, United States Department of Justice, September 2001. Available at: https://www.ncjrs.gov/pdffiles1/ojjdp/188677.pdf

31. American Psychiatric Association. Conduct Disorder Fact Sheet, DSM-5. 2013. Available at: http://www.dsm5.org/Documents/Conduct%20Disorder%20Factsheet%20Rev%209%206%2013.pdf.

4.9 Inadequate Service Response

The Agency employs a prevention worker to provide social development activities within the community. This program is separate from the child protection unit. However, there is a process in place for at-risk families to be referred to the prevention worker, if required. This worker reported to the Advocate having had several contacts with Derek's family in 2012, either through community initiatives or chance meetings, but that she was not aware they were involved with child protection services.

An Agency investigator told the Advocate that when he initially reviewed the file, he "knew [Derek] was falling through the cracks."

In April 2012, Derek's school wrote a third letter to the Agency "plead[ing]" for assistance in supporting Derek and his family. They invited the Agency's child protection staff to participate in a meeting with Derek's parents and other community partners to assist with the development of an action plan to provide these supports. While MSS identified in their review of this incident that an Agency investigator was present at this meeting, there was no documentation in the Agency's file to confirm their attendance. The prevention worker was separately invited to attend the meeting. Although a plan for working with Derek was developed through the school, no follow-up with the family was conducted by the Agency. This was another missed opportunity for the Agency to assess the family's needs and provide services.

In August 2012, Derek's father was charged and convicted of assaulting Derek. There was no indication on the file that this matter was reported by the RCMP to the Agency as a child protection concern. According to the Provincial Child Abuse Protocol, matters such as this should be coordinated between police and child protection authorities.[32]

On a separate occasion, the RCMP provided information to the Agency indicating that Derek had witnessed a violent aggravated assault that had occurred in the community in November 2012. It appeared, once again, that no supports were offered to Derek at this time.

The RCMP contacted the Agency in December 2012 to discuss Derek's circumstances and to ask that the Agency ensure all relevant information on his inappropriate behaviours was shared with the mental health therapist. The Agency investigator assigned to this matter contacted the central office to collect information on past intakes and investigations. Central office informed the investigator that the report assigned to him was the only one that could be located, in spite of at least seven child protection reports having been made to the Agency by this time. This Agency investigator told the Advocate that when he initially reviewed the file he "knew [Derek] was falling through the cracks."

One month later, the Agency spoke with the mental health therapist, school officials and the RCMP to gather additional information on Derek's behaviours. However, no further investigation was conducted and the family was not seen. By this time, the Structured Decision Making® (SDM®) model had been introduced, and the Agency was required to follow these standards. Agency documentation indicates staff determined that a Safety Assessment—which is used to identify safety threats and whether capacity exists to keep a child safe in the home during the period of an investigation—could not be completed "because of a lack of information and the sensitive nature of the investigation." However, according to SDM® policy a Safety Assessment should have been conducted at this time.[33]

In January, and again in February, 2013, the RCMP reported additional concerns to the Agency about Derek's inappropriate actions toward another child in the community. These were the eighth and ninth Intake Reports documented to date. There is no indication that the eighth report was reviewed by a supervisor or that the Agency took any action on this matter.

Upon receiving the ninth report, the Agency conducted a home visit during which Derek's mother indicated she was unaware of the cause of his behaviours. There was no indication that Derek was seen at this time, contrary to investigation policy.[34]

The mental health therapist who had been intermittently involved with Derek and his family advised she was unaware of the FASD diagnosis or its recommendations

What is FASD?

Fetal Alcohol Spectrum Disorder, commonly known as FASD, is a neuro-developmental disability that occurs when a woman consumes alcohol during her pregnancy. Exposure to alcohol affects the developing baby's brain and central nervous system, and it can have an impact on many areas of a child's development, including physical, cognitive and social development, as well as behavior and the ability to learn. FASD is called a spectrum disorder as there are different diagnoses for people with FASD, and differing levels of disability, from mild to severe.[35] The FASD Support Network of Saskatchewan notes that it is mostly an invisible disability, because we cannot see the physical changes in the brain as a result of prenatal alcohol exposure that cause permanent impairments. This invisibility can make it difficult for it to be diagnosed, and for people with it to get the supports they need.[36]

Health Canada estimates that every year in Canada, nine out of every 1000 babies are born with FASD, and that there are 300,000 people living with FASD at any given time. While FASD is considered preventable, in that it only occurs when a woman has consumed alcohol during her pregnancy, it cannot be considered completely preventable, as there are many reasons a woman might drink while pregnant. These can include not knowing she is pregnant, not knowing about the risks of drinking while pregnant and addiction issues.[37]

Health Canada notes that "[t]hose who live with FASD may have mild to very severe problems with their health. They may have delays in their development, intellectual problems and problems in their social lives."

Examples of these problems include:

- learning disabilities, particularly in mathematical concepts;
- difficulty understanding the consequences of their actions;
- mental health issues such as depression or obsessive-compulsive disorder;
- physical disabilities such as kidney and internal organ problems;
- and skeletal abnormalities such as facial deformities.

There is no cure for FASD. People live with FASD for their entire lives, so early intervention is key to minimizing the disabilities associated with it, according to Health Canada.

However, individuals affected by FASD and those advocating on their behalf indicate that impulse control can improve over a person's lifetime. They state that in adulthood, many people along the FASD spectrum can live healthy lives, and engage in careers and their communities, provided they are given proper supports and greater understanding.[38]

In April 2012, Derek's school wrote a third letter to the Agency "plead[ing]" for assistance in supporting Derek and his family

32. Government of Saskatchewan. Provincial Child Abuse Protocol, 2006. Available at: http://socialservices.gov.sk.ca/child-abuse-protocol.pdf

33. Children's Research Centre, The Structured Decision Making® System for Child Protective Services, 2012: 46

34. MSS, Family-Centred Services Manual, Ch. 3, Sec. 11

35. Health Canada / Public Health Agency of Canada. Fetal Alcohol Spectrum Disorder. It's Your Health fact sheet series. 2006. Available at: http://www.hc-sc.gc.ca/hl-vs/iyh-vsv/diseases-maladies/fasd-etcaf-eng.php

36. FASD Support Network of Saskatchewan Inc. What is FASD? [web page]. Available at: http://www.skfasnetwork.ca/main/learn-about-fasd/what-is-fasd/

37. Poole N.A. Fetal Alcohol Spectrum Disorder (FASD) Prevention: Canadian Perspectives, 2008. Public Health Agency of Canada. Available at: http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/fasd-etcaf/publications/cp-pc/pdf/cp-pc-eng.pdf

38. Changing the Conversation: the 6th National Biennial Conference on Adolescents and Adults with Fetal Alcohol Spectrum Disorder (FASD). University of British Columbia, April 2014. More information available at: http://interprofessional.ubc.ca/AdultsWithFASD2014/

A decision was then made by Agency staff that no further follow up was required, as they believed the RCMP was investigating the matter. There is no record of investigator consultation with a supervisor regarding this decision to stop the investigation. Whether the RCMP was pursuing a criminal matter or not, child welfare agencies still have a responsibility for ensuring the safety of the children involved. This was not done for Derek.

In April 2013, the Agency completed a Safety Assessment and documented grave concerns that Derek may be at risk of harming himself or other children

Concerns over Derek's behaviour at school persisted. As a result, the school asked that he be kept at home until these issues could be addressed. The school contacted the Agency who conducted another home visit on March 8, 2013. This was the first documented instance through out the four and half years of Agency involvement where Derek was actually spoken to by an Agency staff member.

During this conversation, Derek was reportedly hearing voices. The Agency and the parents discussed the possibility of admitting him to a therapeutic facility. Derek's parents reported to the Advocate that they had questions about this, but were not given clear answers by Agency staff. As a result, they were resistant to the idea and Derek remained at home.

When they closed their file on August 8, 2013 after speaking with the Agency, it was the RCMP's belief that things were going well and that the Agency would monitor the family and Derek's safety

At this time, Derek's parents advised Agency staff that he was going through the FASD assessment process. However, specific information in this regard was not provided to or pursued by the Agency. After this home visit, the Agency arranged to get Derek back into school and to have an appointment with his psychiatrist. The RCMP again expressed to the Agency that it appeared to them that Derek had not been getting the services he required.

In April 2013, the Agency completed a Safety Assessment and documented grave concerns that Derek may be at risk of harming himself or other children. When safety threats are identified, SDM® policy requires a Safety Plan be completed immediately. However, a Safety Plan was not reviewed with the parents until June 2013. Furthermore, the Safety Plan did not take adequate steps to ensure Derek's protection. The Agency only committed to ensuring that he attended all scheduled psychiatric appointments.

Later in June 2013, Derek's father was absent from the home and his care was left solely to his mother. The Agency made two visits in July 2013, but neither Derek nor his mother was home. The Agency appears to have made no further efforts to locate them, despite the serious concerns previously identified.

Derek's third appointment with his psychiatrist took place on July 16, 2013, over one year after his last two visits and one month before Sam's death. The psychiatrist adjusted Derek's medication at that time to manage increasing hyperactivity. There was no indication on Derek's file that the mental health therapist or the Agency followed up on this visit in any specific manner.

On August 8, 2013, the RCMP closed their file from the previous December after speaking with the Agency. Based on this discussion, it was the RCMP's belief that things were going well and that the Agency would monitor the family and Derek's safety.

4.10 The Evening of August 21, 2013

We may never know the details of what happened three weeks later, on the evening of August 21, 2013. What we know for certain is Sam died of blunt force trauma and that the RCMP suspect Derek of being responsible. Derek was apprehended by the Agency while in RCMP custody that evening and was eventually transferred to a child resource home. He remains there today under the care of social workers and medical staff.

5. ADVOCATE'S FINDINGS RESPECTING DEREK

When the Advocate travelled to Derek's community to speak to his mother, he observed that this family was living in poverty. It is well known that First Nations and Métis people have suffered from intergenerational trauma, brought about by the colonial government policy of assimilation, which led to the residential school system. First Nations and Métis people have experienced many losses which have resulted in social exclusion, poverty, addictions, violence and mental health issues. The forced removal and loss of children from First Nations communities can be linked to the challenges of today, including the over representation of First Nations youth and families in the child welfare system in Saskatchewan. The Advocate acknowledges these truths as part of our shared journey of reconciliation in child welfare.

The Advocate observes that, given the social determinants that threaten the health and well-being of First Nations and Métis people, there is an even greater need for child welfare agencies to ensure that required services are provided to children and families at risk.

In general, our investigation found that Derek was and is an extremely vulnerable child with significant complex needs. His family faces many challenges that could put children at risk. As a result, he and his family would have benefited from prevention and early intervention services earlier in his life. For example, this could have led to more timely recognition of symptoms of FASD, rather than having this occur when he was already nine years old. Once Derek entered school, the school system made considerable efforts to address his needs, as did the RCMP. More could have been done by the Agency to support these organizations in addressing their concerns.

The Agency tasked with protecting Derek and supporting his family failed them in many ways. Serious gaps in the provision of services and omission of critical steps culminated in an overall failure to provide him with necessary services to which he was entitled and to protect his safety and well-being. The nature of the concerns reported to the Agency should have warranted a stronger response.

Principles of good social work practice were either not known to Agency staff due to deficiencies in hiring or training, or they were simply not practiced. There was a lack of proper supervisory oversight and poor communication between staff and supervisors. Agency investigators did not know what family services workers were doing and vice versa; prevention workers did not know what child protection workers were doing and vice versa. The Agency was deferring to the RCMP when they should have acted notwithstanding RCMP involvement. Child welfare assessments and required documentation were not completed and not signed off by supervisors. When forms were signed, this often took place many months after they should have been.

As mentioned previously in this report, the *Saskatchewan Children and Youth First Principles* stipulate that a child is to be treated as the primary client, at the centre of any child serving system that influences his or her life. Several examples noted above and summarized below have shown this was not the case for Derek. The Advocate identified many opportunities to address Derek's significant needs—both as an individual and as part of a family—and to provide helpful interventions at a much earlier stage.

These opportunities were missed.

In particular, our investigation noted these concerns:

Given the social determinants that threaten the health and well-being of First Nations and Métis people, there is an even greater need for child welfare agencies to ensure that required services are provided to children and families at risk

5.1 Intake Process

Finding #9: ***The intake process used by the Agency throughout their involvement with Derek and his family was significantly problematic. Problems included delays in completing Intake Reports, ineffective documentation and file management, and insufficient supervisor oversight. Issues at the intake stage created barriers to investigations being conducted in a timely and effective manner.***

In some instances, Intake Reports were completed a number of days after the Agency received the concern. This delay ranged from three to ten days. Furthermore, four out of the nine Intake Reports created by the Agency did not include a designation of either "immediate" or "non immediate"; instead, the section designating urgency was left blank. As per provincial policy, concerns designated as requiring "immediate" investigation must be responded to within 24 hours. Those designated as "non immediate" are to be responded to within five days.[39] These shortfalls prevented Agency investigators from responding to child protection concerns within the required timeframes.

39. MSS, Family-Centred Services Manual, Ch. 3, Sec. 9; Children's Research Centre, The Structured Decision Making® System for Child Protective Services, 2012: 30

Due to what the Agency described as a "rudimentary" system of recording and tracking intake information, Intake Reports did not include all information regarding past referrals. Those that did have information recorded, incorrectly identified the number of child protection concerns that had been reported. In addition, file information was stored in various locations within the Agency. This resulted in Agency staff being unaware of other involvement with the family. Policy states that supervisors have an obligation to ensure staff have access to all relevant information needed to adequately case manage.

Derek is documented to have been interviewed only once in the four and a half years the Agency was involved with his family

Issues present at intake impeded the process of effectively assessing and responding to child protection reports, which impacted the timeliness of investigations.

5.2 Quality of Investigations

Finding #10: ***Overall, investigations by the Agency displayed several deficiencies. These included delays in initial response times, lack of information gathering, and failure to meet documentation timelines. This affected the Agency's ability to accurately assess risk and ensure that Derek was safe.***

The Agency documented nine child protection concerns in the appropriate Intake Report format. On two occasions there was no documented investigative response. In the cases that were investigated, meaningful action by the Agency was severely delayed—often taking place months after the concern was received.

Investigations that were undertaken were not comprehensive. In many instances, both parents were not spoken to and the children in the home were not interviewed. As mentioned above, Derek is documented to have been interviewed only once in the four and half years the Agency was involved with his family prior to August 21, 2013. Additionally, on two occasions Agency staff failed to take appropriate action out of reported concern for "contaminating" parallel investigations by the RCMP. In these cases, the Agency was still required to fulfill their child protection obligations under *The Child and Family Services Act*.

The Advocate also found that required assessments were either not completed during the course of investigations, or were done months later. For example, only two of the seven investigations conducted by the Agency included a Risk Assessment. These were completed three and nine months after they became aware of the concerns, rather than within the 15-day period required in policy.

Safety Assessments and Safety Plans were not completed in two of three concerns received after the SDM® model was introduced. The one that was completed was significantly late and did not sufficiently address the risks identified to Derek and others. Furthermore, the majority of investigations were ceased without completion and supervisor approval of the required Investigation Record.

Without timely responses and comprehensive investigations, it is impossible to accurately assess risk and ensure that children are safe.

5.3 Quality of Case Planning

Finding #11: ***Case planning for the family did not comply with policy. The services provided were not timely and did not meet the family's needs.***

Even though Derek and his family were determined to be at high risk early in their involvement with the Agency, processes of case planning and service provision were not timely, nor did they adequately meet the family's needs. For example, the Parental Services Agreement was not implemented with Derek's mother until months after the Agency received reports of concern for the children's safety. This Agreement was inadequate as many concerns went unaddressed. For example, services for Derek's father were not included, even though it was known to the Agency that he had sole care of the children at the time it was signed. Increasing parenting skills was identified as a need for Derek's mother, yet supports to assist her in this regard were not put in place.

Most important, Derek's needs were not addressed in the Parental Services Agreement. Concerns about his behaviour were known to the Agency, but were not appropriately communicated to staff responsible for developing or implementing the Agreement. As a result, services to address Derek's needs were not provided.

Similarly, the Assessment and Case Plan completed was overdue by more than one year. In March 2010, the requirements of the Parental Services Agreement had not been met. However, a Risk Assessment was completed which rated the family's risk level as *low* and the Assessment and Case Plan indicated the file would be closed. There was no further case planning with

Derek or his family until a Safety Plan was created in June 2013. By that time, concerns with Derek's behaviour had escalated and the intervention identified in the Safety Plan was not sufficient to ensure his protection.

Agency contact with Derek's family was sporadic. Appropriate case planning would have dictated the frequency of contact required for the Agency to have with this family. Increased contact would have allowed Agency staff to better understand the needs of Derek and his family and to put services in place in a more timely manner.

More comprehensive investigations would have gathered information from Derek's 2010 Psycho-Educational Report and his 2012/2013 FASD assessment. These reports identified services he required that could have been built into the case plan. Case planning also would have been enhanced by the use of SDM® Family Strengths and Needs Assessments, which are tools to formally explore and identify critical family issues. These Assessments were not used by the Agency. Additionally, the Agency could have arranged for case conferences between service providers to assist in case planning and facilitate continuity of services.

With the information that would have been obtained by taking these steps, the Agency would have been in a better position to identify Derek's needs and accurately assess whether his family required assistance to meet these needs. This could have included ensuring Derek had the supervision he required or helping his mother to connect with the FASD Support Network. As these critical steps were not taken, this vulnerable family was left on their own to access services.

5.4 Supervision

Finding #12: *Casework supervision did not comply with policy. Supervision was largely absent, or at least not appropriately documented.*

There were supervisory deficits in services provided to Derek and his family. Policy requires that a supervisor be consulted in the decision whether or not to investigate and document their direction to investigations staff.[41] Several Intake Reports did not have a signature, a date or direction from a supervisor. When there is no signature, there is no way to confirm that appropriate supervision occurred.

Additionally, supervisors were not ensuring that all available information on reports concerning Derek and his family was being provided to each new Agency investigator.

In general, investigations lacked adequate supervision. Again, numerous documents did not have a supervisor's signature, or were signed off months later. The lack of supervisory oversight was also evident in the failure to adhere to timelines or other policy requirements noted above.

In some instances, although appropriate supervisory direction was provided on an Intake Report, the suggested actions were not taken during the investigation. There did not appear to be any follow-up by supervisors to ensure these things were done. Appropriate and consistent supervision would have helped to facilitate effective communication between various staff members and Agency departments, as well as to improve the quality of case planning.

There were supervisory deficits in services provided to Derek and his family

More attentive supervisory guidance and oversight would have provided consistent decision-making, greater accountability and better outcomes for Derek and his family.

5.5 Staff Training and Qualifications

Finding #13: *The lack of formal qualifications, job orientation and training for staff left them ill-equipped to deliver quality child and family services.*

Many Agency staff members involved in this case lacked the capacity or understanding required to provide basic child welfare services. The Agency reported they made efforts to staff positions with individuals holding degrees in Social Work, but they were often unsuccessful in recruiting and retaining people with these qualifications to work in remote communities. MSS reported to the Advocate that they were aware of issues related to staff qualifications. Accordingly, MSS efforts were directed at assisting the Agency with training.

MSS "CORE" training covers provincial policies and procedures and is usually delivered in intervals over a five month period. New hires at the Agency may have missed this training or had it delayed. In Derek's case, several staff had no CORE training and others had completed only part of the training.

41. MSS, Family-Centred Services Manual, Ch. 3, Sec. 5 & 6

Although the SDM® model was implemented in September 2012, training was not provided to staff involved with Derek's family until almost a year later. This delay was likely a factor in why the Safety Plan created by the Agency in June 2013 did not sufficiently meet Derek's needs.

The Advocate found there was a substantial lack of quality in the orientation of child protection staff involved in this case. Most child protection investigators were provided only with the opportunity to review mock files and were then assigned to investigations in the field. Considering that many did not receive CORE or SDM® training at the outset of their employment, a more intensive orientation, training and supervision process would have been more effective.

Derek received services by health care professionals in urban centres, but once he returned to his community, he and his family were largely left to look after themselves

Training was provided to supervisors responsible for Derek's case. However, one of these supervisors reported to the Advocate that she took on a managerial position despite being concerned about her own competency to fulfill that role. This supervisor described being overwhelmed by the busy and demanding pace of the work and stated that much-needed mentorship was not provided. The Agency conceded that some managers were inexperienced.

In general, Agency staff who worked with Derek and his family—at all levels—did not appear to have the required knowledge or understanding of policies, procedures, and protocols including *The Child and Family Services Act*, the *Provincial Child Abuse Protocol*, the *Touchstones of Hope for Indigenous Children, Youth and Families* or the *United Nations Convention on the Rights of the Child*.

5.6 File System and Information Management

Finding #14: *The Agency lacked adequate record-keeping and information management practices at the time of involvement with Derek's family.*

Agency staff told the Advocate that documentation related to Derek and his family was not all consistently stored in one location. Information was held by either the central office, a sub-office or by individual staff members. There was no electronic database in use that allowed for all Agency staff to access these records. Following Sam's death, the Agency gathered relevant information from these various sources and compiled a file that was presented to the Advocate for the purposes of this investigation.

This situation was a factor in problems with the intake process previously noted and why Agency investigators were unaware of previous involvement with the family. Furthermore, this also contributed to the lack of communication between investigations and the family services worker providing ongoing services to Derek's mother. This resulted in more missed opportunities to address Derek's needs.

The Agency has recognized this pitfall and is taking steps to implement a new database to improve information management.

5.7 Access to Health Services

Finding #15: *Derek received an FASD assessment and information was provided to his mother in this regard. However, Derek did not have access to necessary follow-up services to support him and his family.*

Derek received services by health care professionals in urban centres, but once he returned to his community, he and his family were largely left to look after themselves. The mandate of the medical team who assessed Derek for FASD is for assessment and diagnosis only. Follow up only occurs every two to three years. Without appropriate supports, it is difficult for vulnerable parents living in rural or remote communities to access necessary resources for their children.

The Advocate was advised that no program mandate exists in Derek's part of the province for any particular organization to work specifically with the FASD population. A multi systemic framework is vitally needed to address the needs of individuals with prenatal alcohol exposure. Cases like Derek's show a need for greater collaboration between child welfare agencies, the health care system, education and the justice system.

More needs to be done to aid children with developmental disabilities and mental health issues, particularly in rural and remote areas.

The Advocate recognizes there are many challenges faced by frontline child protection staff in this province. Child welfare is one of the most complex services that Government and First Nations Agencies provide. Child protection workers are held to very high standards while at times facing seemingly insurmountable barriers. These barriers were identified by MSS and the Agency to include unmanageable work load demands, high worker to supervisor ratios, travel required to visit remote communities, long wait lists for clients to receive public services and a shortage of services in rural areas.

The SDM® model has been useful in creating therapeutic relationships with families and instilling confidence in the consistency of decisions. However, it was reported that the increased assessment and contact standards have put even more pressure on child protection workers who struggled to maintain the previous requirements. It was made clear to the Advocate by MSS and Agency staff that child protection workers cannot keep up with these requirements.

Children have a right to be safe. Therefore, child welfare must continue to be held to the highest standard. Sections 3 and 4 of *The Child and Family Services Act* are clear in its mandate to ensure the best interests, protection and safety of children. The *United Nations Convention on the Rights of the Child* demands nothing less. The system must provide child protection staff with the support they need to achieve these objectives.

The Advocate has an open recommendation to the Government of Saskatchewan to amend *The Child and Family Services Act* and its regulations to include a provision that defines maximum supervisor to child protection worker ratios and caseload standards for all workers within the child protection system. A method for determining these standards is recommended in this report.

Early childhood programming

Programs such as prekindergarten, child care, preschool, and family resource centre programs significantly benefit young children. In early childhood, children are undergoing rapid development and they are highly sensitive to their environments. Experiences in early childhood have lifelong impacts on children's health and well-being, and that of their families and communities.

Early childhood development programs also provide opportunities for trained professionals to identify children with developmental delays and other needs, and connect them with services to address these needs earlier, before children reach kindergarten and the developmental issues become more challenging. These kinds of programs can also have a positive impact on parents.[39]

In 2012, the Government of Saskatchewan, Federation of Saskatchewan Indian Nations and the Métis Nation of Saskatchewan convened a Joint Task Force to listen to communities, seek a vision for action and recommend ways to improve education and employment outcomes for First Nations and Métis people. One of the Task Force's recommendations in its final report was that the province work with the federal government and First Nation and Métis authorities to develop and implement an Early Childhood Strategy to reach all children in Saskatchewan.[42]

Ultimately, widely available and accessible prevention and early intervention services for children and their families are an effective use of public resources, as they have been shown to reduce later costs to systems such as health, social services and corrections.[43]

The increased assessment and contact standards with SDM® have put even more pressure on child protection workers who struggled to maintain the previous requirements

42. Federation of Saskatchewan Indian Nations / Government of Saskatchewan. The Joint Task Force on Improving Education and Employment Outcomes for First Nations and Métis People. Final Report, March 2013, p. 41. Available from: http://www.jointtaskforce.ca/

43. See for example: McCain, Hon. Margaret Norrie; Mustard, Fraser J. & Mccuaig, Kerry. Early Years Study 3: Making decisions, taking action. 2011. Margaret & Wallace McCain Family Foundation, available at: www.earlyyearsstudy.ca; Neudorf C, Muhajarine N, Marko J, Murphy L, Macqueen Smith F, Clarke A, Ugolini C, Wu J. Healthy Children, Healthy Families, Healthy Communities: A report of the Chief Medical Health Officer on the health status and development of young children in Saskatoon Health Region, 2012. Saskatoon Health Region; Nov 2012. Available at: http://www.saskatoonhealthregion.ca/your_health/PHO/SHR_Healthy_Families_2012.pdf; World Health Organization. Closing the Gap in a Generation: health equity through action on the social determinants of health. Commission on the Social Determinants of Health. Geneva, 2008.

The examination of the histories of these two boys provided an opportunity for the Advocate to review what is being done by those accountable for ensuring that quality standards for child protection are being upheld in this province. This section of the report examines the mechanisms and structures for accountability that are intended to ensure a high quality of services are delivered to children and their families.

7.1 Quality Assurance – Monitoring Compliance to Policy

MSS operates a Quality Assurance Unit to assist both MSS staff and First Nations Agencies with oversight and accountability for their services. The Quality Assurance Unit conducts periodic reviews of MSS and Agency files to ensure compliance with provincial standards. They inform regions and agencies about non-compliance or gaps in service, and they work with MSS's service areas to develop and follow up on the recommendations where non-compliance is found.

Quality Assurance Unit reviews do not capture "outcome data" related to whether the services provided actually improve the lives of children and families served

MSS advised the Advocate that they recognize there are shortcomings in this method as it only captures what is documented on the file, which may not reflect the quality of the service provided. Recommendations are understandably driven by plans to improve compliance. Clearly compliance to policy and standards is critical. However, the reviews do not capture "outcome data" related to whether the services provided actually improve the lives of the families or children served.

There is also a discrepancy in the frequency of these reviews. The reviews are conducted annually for each MSS service area and every three years for a First Nations Child and Family Services agency. There was not a clear explanation provided to the Advocate by MSS for the difference in frequency. It has been suggested that it might be found in the agreements between the Agency and MSS, or due to the fact the federal government requires agencies to undergo other reviews that can complement those done by MSS.

7.2 Quality Assurance Unit Review – Ministry of Social Services

In 2011/2012, the Quality Assurance Unit completed a review of the case management standards for the MSS region that provided services to Sam. The results were compared to the review of the previous year to determine areas where improvements had been made or where an issue of compliance with standards was identified. In particular, the Quality Assurance Unit made recommendations for improvements to several areas, including Investigation Records, Assessment and Case Plans, supervision and contact standards.

That said, the fact that plans were underway to address these issues—such as training, clinical supervision, and use of additional supervisory mechanisms in MSS's new database program—did not prevent some of these issues from arising in Sam's case about a year later.

7.3 Quality Assurance Unit Review – Yorkton Tribal Council Child and Family Services Inc.

The Quality Assurance Unit also completed reviews for the Agency in 2009 and 2013. The 2009 review examined active child care and caregiver resource files. It did not look at active family services files, which would have included the type of services being provided to Derek and his family. These files were located at the Agency's sub-offices during the time of the review and were not available to the review team.

The 2013 review included sampling of 15 family services files from the Agency sub-offices. The review was not finalized or shared with the Agency until November 2013, three months after Sam's death. That review found evidence of good practice in family engagement, improved supervisory oversight in contact notes and implementation of the SDM® tools.

Non-compliance, however, was identified in 2013 in the following areas:

- Safety Assessments and Risk Assessments were not always completed;
- contact standards in child protection cases were not met;

- Investigation Records and Assessment and Case Plans were deficient;
- Parental Services Agreements were not always completed; and
- file supervision did not always meet standards.

The compliance review findings in terms of good practice do not reflect the evidence found by the Advocate pertaining to Derek's case. Our review found that this family was not appropriately engaged or offered services, supervision of work and documentation was often absent and use of the SDM® tools was inadequate.

As a result of the November 2013 review, recommendations were made that the Agency develop a plan to address the areas of non-compliance. The Agency responded to this review and outlined what it would cost to address the recommendations. Their plan includes training for staff in areas of non-compliance, hiring additional staff to manage their database, and enhancing processes for supervisory oversight on cases.

The Advocate appreciates that compliance and quality assurance are a continuous improvement process and results take time. However, recommendations for additional training or methods to improve supervisory oversight do not appear to be addressing some of the underlying issues identified in this investigation. Methods to measure competency and development of clinical oversight by qualified staff need to be considered.

7.4 Child Death and Critical Incident Reviews

The Quality Assurance Unit is also responsible for conducting Child Death and Critical Incident Reviews (now known as Serious Occurrence Reviews). These include cases where a child or youth dies or is critically injured, and has received services from MSS or an Agency within the previous twelve months. These reviews are intended to examine whether the services provided were in accordance with Ministry policies and also whether they were of sufficient quality. These reviews have greater capacity than the periodic compliance reviews to identify and address broader issues that may be found. Policy specifically describes identifying internal and external systemic issues that impact client service and outcomes. Recommendations can be made to improve service delivery or system improvements including system redesigns or policy changes.

The recommendations from all compliance, Child Death and Critical Incident Reviews are tracked provincially. It has only been in the last few years that the Quality Assurance Unit has been collecting all the recommendations in a database. Reports drawn from this data can include recommendations made by the Advocate and the Office of the Provincial Coroner. They do not consider trends until they have several years of reviews completed across the province. This will allow them to identify where improvements are required. It is not clear whether this process enables MSS to identify, track and monitor issues where recommendations are not made.

Child Death Review of Services to Sam

The MSS Child Death Review considered the complete history of MSS's involvement in the lives of Sam and his family. However, the Advocate has found areas not comprehensively covered by the review. The plan for Sam was reunification with his family, yet the review did not address the impact of delay of services to Sam's parents or the lack of an assessment of Sam's father as a resource. The recommendations of the Child Death Review focused on developing plans to deal with non-compliance in the use of SDM® tools, and for addressing timelines and improved documentation.

Recommendations for additional training or methods to improve supervisory oversight do not appear to be addressing some of the underlying issues this investigation identified

While the review found workload demands to be a barrier to completion of documentation needed for adequate supervision, there was no recommendation to deal with this issue. High workloads negatively impact the quality of case practice. This has been identified by the Advocate as a longstanding issue in child and family service delivery and requires tracking. The review process needs to examine in detail the barriers that affect the plan for the child and family and there needs to be greater emphasis on addressing any systemic issues that are found.

Critical Incident Review of Services to Derek

The Critical Incident Review was completed by the MSS's Quality Assurance Unit and the Agency. It found areas of significant deficiencies in case practice. Systemic issues were identified, including the ability of the Agency to recruit and retain qualified staff, the Agency's administrative procedures, access to specialized resources and information sharing with police and other service providers. The recommendations of this review were comprehensive and provided direction to address the scope of issues found.

The Agency reports that federal funding does not cover specialized services for at-risk families when children remain at home or there are plans for them to return home from care

That said, the Quality Assurance Unit was not able to obtain information from some of Derek's health providers within their timeframes and reported that they had no ability to compel this information. The Advocate is concerned about this limitation.

7.5 Previous Child Death Review

This is not the first time that this Agency's services have been examined by the Advocate. In 2011, the Advocate provided MSS and the Agency with the results of its own investigation into the death of a child where services had been provided by the Agency some years earlier. In that review, the Advocate found the Agency's child abuse investigation failed to gather all relevant information and this impacted on the ability of staff to properly assess the risk to this child and establish an appropriate case plan for the family.

The Advocate also found non-compliance with policy related to Assessment and Case Plans, Parental Services Agreements, use of Risk Assessment tools and supervisory oversight. At the time, MSS was introducing its SDM® assessment tools and had indicated that all staff who deliver child and family services would be trained in its use.

In response to the Advocate's report, MSS and the Agency reported that staff had taken training on areas where non-compliance had been found. The Agency was piloting SDM® at one of its offices. It also had plans to develop an internal quality assurance team and training body to build training components specific to child protection investigations and case management. The Advocate concluded its case at that time on the basis that the issues identified were in the process of being addressed.

7.6 MSS's Agreement with the Agency

The Child and Family Services Act allows the Minister of Social Services to enter into agreements with a band or any other legal entity for the provision of services or the administration of all or any part of the *Act*.[44] MSS entered into such an agreement with the Yorkton Tribal Council and Yorkton Tribal Council Child and Family Services Inc. (the Agency).

The Tribal Council operates the Agency to provide child and family services. The Agency is a separate legal body from the Tribal Council and is incorporated under *The Non-profit Corporations Act, 1995* as a membership corporation. The Tribal Council member chiefs delegate the policy and program development to a Board of Directors and its staff. The Board of Directors has overarching responsibility for the operations of programs delivered by its Executive Director and staff.

The Agreement with this Agency is unique in comparison to later agreements with other agencies. For example, it has no renewal or end dates and has less specific reporting requirements. The accountability requirements in this Agreement are general and broadly worded. The Agency is required to provide an annual report to its First Nations members and to the province. In addition, the Agency is required to supply the province with access to information pertaining to its day-to-day operations. The province is required to provide the Agency with access to information required for the effective management of the program and any other information that may be agreed upon in future protocols.

Protocols could guide the relationship between the Agency and MSS and provide clarity about the responsibilities and expectations of the parties. Several protocols found in provincial policies, such as the

Case Transfer Protocol, are in use, but the majority of those referenced in the Agreement remain outstanding. For example, the Agreement contemplates protocols covering staff training and development and child abuse investigation procedures, areas that have been identified as challenges for this Agency.

This Agreement contains provisions for the Agency to develop and implement standards to ensure that it provides a comparable standard of care as required under provincial legislation. However, the Agency has not developed its own policies or standards, but uses provincial policies. The Agency must also follow federal requirements for services it delivers to children it places in an out-of-home resource.

The Advocate observes that while MSS has an Agreement with the Agency to provide services to the community that would otherwise be provided by MSS, MSS continues to be accountable for the safety and protection of all children requiring services under the *Act*. Therefore, MSS is responsible for meaningful oversight of these agencies to ensure services are provided in accordance with the *Act* and in compliance with its standards.

7.7 Agency Funding and its Relationship to Services

By entering into this Agreement, the Agency was able to obtain funding from the federal government to provide child and family services to its First Nations families and children resident on reserve. However, the Agency reports that federal funding does not provide for specialized services for at-risk families when the children remain at home, or when there are plans to return a child home and supports are needed for the family.

This report did not examine whether this Agency receives adequate funding. This matter is currently the subject of a federal human rights complaint. The Advocate is concerned that disparities in the types of services that can be funded have not been addressed. First Nations families and their children are entitled to services that at least meet the standards that are provided by MSS.

The Agency is also funded to provide prevention services and has developed a community-based prevention program to assist its communities to become stronger and healthier. The Agency has acknowledged that its internal policies related to the link between its prevention and protection services were not established in practice and there was seldom any connection between the programs.

This is most unfortunate as communities need to understand and have access to child welfare services. The Agency needs to urgently examine the operations of its prevention program and how this program interfaces with its protection services.

7.8 MSS's Oversight of the Agreement

MSS Child and Family Services, Community Services Branch (First Nations and Métis Services Unit) is responsible for oversight and maintenance of Agreements with First Nations Agencies to deliver child and family services. MSS advises they use a collaborative and supportive approach in managing the agreements and they rely on the agencies to carry the primary responsibility for service delivery. The unit employs First Nations consultants to work directly with the agencies. These consultants generally request agencies to provide MSS with an outline of their programs and services, the names and qualifications of their staff, their audited financial statements and a list of their approved foster homes.

The Agency needs to urgently examine the operations of its prevention program and how this program interfaces with its child protection services

The consultants also arrange training for agency staff on MSS policies and practice standards and act as a liaison involving case specific issues arising between agencies and MSS. On an annual basis, these consultants develop their own work plan that includes follow-up on recommendations made in the various compliance, Child Death and Critical Incident Reviews, in addition to ensuring the required reports are filed by an agency.

44. The Child and Family Services Act, Sec. 59

As the oversight body, MSS maintains a file containing information about this Agency. As noted previously, the reporting requirements in the Agreement with this Agency are not specific and this appears to have affected the lack of information contained on the MSS file. For example, later agreements direct an agency to provide specific reports to MSS, including a list of Agency staff and their qualifications, criminal records and child abuse checks. The MSS file for this Agency did not contain that information and the First Nations consultant reported that MSS had not specifically requested them.

The capacity of the Agency in all its functions is vital to its ability to provide quality services to protect children and promote sustainable child welfare

We see this as problematic, particularly as the Agency has identified recruitment and retention of qualified staff as an ongoing challenge.

The MSS file also contained the Agency's financial statements, rules of governance and its 2008 business plan. More current business plans were not found on the MSS file, although the Agency submits them annually to the federal government for funding purposes. These business plans provide significant insight into the Agency's operations, challenges and future planning for service provision. They also provide detail about how their protection and prevention programs were managed.

The consultant had not seen these later plans and reported limited involvement with the Agency's prevention and protection programs. Much of the consultant's work revolved around cases where there were plans to return a child in MSS care to their First Nation. At the time of our investigation, the First Nations consultant assigned to this Agency carried responsibility for four other agencies located across the province.

The MSS file also contained the Agency's 2010 Operational Review. The federal government provides the Agency with funding to conduct operational reviews approximately every three years. The Agency engages a private consultant to evaluate their operations and to provide recommendations aimed at setting direction and improving their program services. The Agency developed work plans to address the recommendations from this review and these were absent from MSS's records. These plans contained details about how the Agency was going to address a range of issues related to management of the entire scope of its operations.

To make its findings related to the Agency's casework, the Operational Review examined files, looked at MSS's 2009 review, conducted staff and client interviews, and held focus groups and surveys. Overall, the review determined that the Agency, for the most part, was delivering quality child welfare services. However, the review found certain deficiencies in some of the Agency's child protection files related to:

- failure to use the Provincial Child Abuse Protocol;
- lack of follow-up in several abuse allegations;
- lack of supervisory direction in a number of cases involving apprehension; and
- issues related to case practice, including:
  - a need for advanced skill development to better utilize the child welfare assessment tools;
  - compliance with contact and visitation standards; and
  - a need for enhanced case management supervision.

It made recommendations related to overall case management and human resources. These included:

- development of a database and case management system;
- the creation of a file review process to address non-compliance with standards; and
- conducting a review of the high staff turnover and developing a strategy to address the retention concerns.

The Agency's response to issues of staff competency, as was noted in previous reviews, has been to continue with training. Adjustments were made to staff salary levels which were hoped to address some of the retention issues. The Agency databases have been in development for several years; currently the Agency uses a foster care and child protection database to track these services. However, not all historical records have been entered in this system. This process is ongoing.

The Agency is undergoing another Operational Review and it will be crucial for MSS to request the results of that review from the Agency. The capacity of the Agency in all its functions is vital to its ability to provide quality services to protect children and promote sustainable child welfare. MSS and the Agency have a good working relationship and there have been no barriers in sharing of information when requested.

MSS reports that it wishes to further develop its relationship with the Agency to assist with service delivery. However at present, MSS appears to be taking a back seat to the Agency's operational issues. For example, the work plans of the First Nations consultants focus heavily on follow up to recommendations from compliance and other MSS reviews and do not include consideration of the overall operations of the Agency.

The Agency Director has commented that he does not feel MSS is listening to the Agency's challenges. He told us MSS "has got to stop viewing all these audits and all these findings and recommendations and implementation plans with their eyes wide shut."

The Advocate tends to agree. MSS and the Agency must begin to take concrete steps to address the fragmented approach to accountability which at present does not appear to provide a comprehensive picture of the capacity of this Agency to deliver quality child and family services. Focusing on only certain parts of the organization's operations is not working,, and repeatedly providing the same training has not delivered the desired results.

7.9 Review of Services to Derek by the Regina Qu'Appelle Health Region

After Sam's death, the Regina Qu'Appelle Health Region files documenting Child and Youth Services involvement with Derek were reviewed by a senior child psychiatrist under contract with the Health Region. Following the review, the senior child psychiatrist discussed the services that were provided to Derek with his psychiatrist. A summary of this discussion was shared with the Advocate. This internal review concluded that Derek received the appropriate care, as a referral was made to a multi-disciplinary cognitive disability team to assess Derek for FASD. It noted that they believed detailed recommendations were provided to local providers of health, social services and education. The review also concluded that more intensive and co-ordinated case management by various agencies involved in Derek's care could have improved the outcome for Derek and his family. The psychiatrists also noted that the special multi-disciplinary team that assessed Derek for FASD did not have the mandate to follow up in his community to ensure that he received the services he needed. In their view, it was "impossible to predict or anticipate homicidal action/risk in a boy of this age with his clinical and developmental features."

Other than the summary provided to the Advocate, it appears these case review observations have not yet been shared or reviewed outside of the Health Region's Mental Health services system.

Derek's case is also to be presented at a Department of Psychiatry Quality Improvement Meeting. At the time of writing, this review had not occurred.

This incident did not trigger the Health Region's Child and Youth Clinical Standards Committee incident review process, as it was neither a "sudden death of a client" or a suicide—circumstances which meet the criteria for review. ◆

MSS is accountable for the safety and protection of all children under *The Child and Family Services Act*. That responsibility includes meaningful oversight for services that are delivered by its service delivery areas and First Nations Agencies. Article 3(3) of the *Convention on the Rights of the Child* states Parties "shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision."

The assessment team believed that Derek required close supervision and that his family needed significant support to care for him and protect others

The Advocate would observe that implementation of this article requires MSS (as the State) to conduct comprehensive reviews of all institutions that are responsible for the care or protection of children.

Our cursory examination of what MSS is doing to manage its Quality Assurance, Child Death, and Critical Incident Reviews, as well as its Agreement with this Agency, leads the Advocate to believe that there is room for more comprehensive consideration of oversight and accountability. The Child Welfare Review conducted in 2010[45] speaks to the need for a collaborative approach to child welfare and preventative family support services within MSS, across Ministries, and with community partners.

As part of this collaboration, enhancements are needed throughout MSS's current accountability structure. First Nations and Métis governments and their agency leaders must be involved in realizing these improvements.

In particular, our investigation noted these concerns:

8.1 Capacity and Frequency of Reviews

Finding #16: *Compliance reviews lack capacity to measure the outcome of services provided to children and families.*

MSS and First Nations Agencies which deliver child and family services need to understand those factors that support quality outcomes as well as compliance to policy. Determining what factors support quality outcomes can assist in development of programs and will help formulate policy.

Finding #17: *Compliance reviews do not occur in First Nations Agencies with the same regularity as MSS service areas.*

First Nations Agencies are expected to deliver comparable services as those provided by MSS and should receive the same level of support from MSS in terms of policy compliance reviews. There is no clear rationale for this difference.

Finding #18: *Child Death and Critical Incident Reviews are limited in their ability to collect information about all services provided by other child-serving systems.*

While the Advocate recognizes that these reviews are for internal purposes, they need to include information from other service providers.

In Derek's case, the Critical Incident Review reflected information from several service providers however did not access information from the Health Region. This information is important in understanding how child welfare services need to be coordinated with other diagnostic, treatment and support services. Collecting this information during a review process would provide the opportunity to begin an immediate dialogue between Ministries and other service providers about ways of addressing service delivery barriers in case practice.

Finding #19: *The circumstances surrounding Sam's death did not result in a comprehensive review of the mental health services provided to Derek by the Regina Qu'Appelle Health Region.*

Although it is noted that professionals felt "homicidal action [or] risk" was not predictable with a child like Derek, the history of severe abuse of animals and a diagnosis of Fetal Alcohol Syndrome, with its attendant issues of compromised impulse control, were known. The assessment team believed that Derek required close supervision and that his family needed significant support to care for him and protect others. Although some follow-up efforts were made, these were not effective in communicating risks and concerns to the professionals in Derek's community in a timely way. Effective follow-up action leading to coordination of mental health services with family and educational services did not occur.

This incident, in which a young child who had been seen by several mental health professionals was allegedly responsible for the death of another child, did not trigger an immediate interdisciplinary review within the Health Region. Consequently the opportu-

Separate review processes limit the ability of each organization to have complete information about their respective program capacity and case management practices and to collaborate on strategies to improve access to and co-ordination of services

nity for mental health professionals to use a comprehensive review process to consider community, social, systemic and clinical issues within their region does not appear to have been taken.

Finding #20: ***Separate review processes do not support a collaborative approach to identify and address broader case management issues.***

It would appear that the separate review processes conducted by the Ministry of Health, its funded authorities, and MSS limit the ability of each organization to have complete information about their respective program capacity and case management practices and to collaborate on strategies to improve access to and coordination of services.

The Advocate understands that the review processes used by each Ministry have different mandates, and are used for specific purposes. However, where a family or child is identified as having significant complex needs, a joint review process will bring knowledge and expertise about the different systems and services required to bridge any gaps identified.

8.2 Operating in Silos

Finding #21: ***The Agency protection and prevention programs were operating in silos. Policy to establish this link was never developed.***

The Agency prevention program was community-based. This program had little or no connection to child protection services. The prevention worker would have been in a key position to provide a link between families needing services and the protection unit within the Agency.

8.3 Progress on the Development of Protocols

Finding #22: ***There has been limited progress to develop the protocols identified in the Agreement.***

MSS and the Agency do not have clear guidelines about their relationship within the delivery of child and family services. There are provisions to develop protocols that could achieve this clarity.

8.4 Approach to Oversight and Accountability

Finding #23: ***The current approach to oversight and accountability is narrow and fragmented.***

The current approach does not provide a comprehensive view of this Agency's capacity to deliver quality child and family services as required by legislation and as contemplated in the Agreement with this Agency.

While MSS has been providing some resources such as training to promote Agency capacity, there is a lack of clear objectives, coordination and timeliness between the Agency and MSS to achieve the goal of a self improving system. ◆

45. Saskatchewan Child Welfare Review Plan. For the Good of our Children and Youth: Saskatchewan Child Welfare Review Panel Final Report. Saskatchewan, 2010, p. 36. Available from: http://saskchildwelfarereview.ca/

9. FINAL THOUGHTS ON A COMPREHENSIVE ACCOUNTABILITY FRAMEWORK

Saskatchewan is working on transformation of its child welfare system, and there is an opportunity to ensure that system accountability is included in this transformation

The Saskatchewan Child Welfare Review Panel has made recommendations related to the overall strategy, goals and priorities of the child welfare system. It is critically important to embed a sound accountability structure into the system, so that all parties who deliver services have a clear understanding of their roles and expectations, and evaluations are conducted that can inform on whether the "right things" are being done.

In September 2012, Ontario's Commission to Promote Sustainable Child Welfare released a report entitled *A New Approach to Accountability and System Management*. It identifies what the Advocate believes are many of the pitfalls of the approach to accountability that have been touched upon here. It speaks to the need for a "more coherent framework of accountability to strengthen governance and secure continuous improvement."[46]

MSS needs to work in partnership to lead this work, building on the direction already set by the Child Welfare Review. Perhaps the First Nations Family and Community Institute could also be a partner. This institute "conducts research and develops First Nation standards and best practices to support First Nation Child, Family and Community Services."[47]

Saskatchewan is now working on transformation of its child welfare system and there is opportunity in this work to ensure that accountability for the system is included in this transformation. ◆

46. Commission to Promote Sustainable Child Welfare. A New Approach to Accountability and System Management. Report and Recommendations. Ontario, September 2012. Available at: http://www.children.gov.on.ca/htdocs/English/documents/topics/childrensaid/commission/2012sept-Accountability_system_management.pdf

47. For information on the Saskatchewan First Nations Family and Community Institute see: http://www.firstnationsfamilyinstitute.ca/

10. ADVOCATE'S RECOMMENDATIONS

The multiple reviews and public reports referenced here highlight recurring challenges throughout the child welfare system. *The "Baby Andy" Report*[48] released ten years ago by MSS and Montreal Lake Child and Family Agency Inc., as well as a review of two child deaths summarized in our office's 2013 Annual Report, identified a number of similar themes and recommendations. Issues related to staffing (including turnover, training and supervision), accountability and compliance with program standards, coordination of services and government support continue to be identified as matters requiring attention to improve the delivery of child welfare services.

The Advocate acknowledges that improvements are being made within both MSS and First Nations Agencies. However, it is clear that more urgency must be placed on the need to move forward on child welfare reform.

The Advocate makes the following recommendations:

Recommendation 1:

That the Government of Saskatchewan develop and implement well-resourced early childhood development and poverty reduction strategies to advance the goals of its Child and Family Agenda.

Adverse events and conditions early in life cause serious harm to children and youth, and significantly reduce their chances of success as they grow older. Inadequate investment in support for parents and young children has profound social, economic, and personal costs for children, their parents, and society as a whole. Children born with prenatal exposure to alcohol resulting in FASD and the apprehension of children from their parents are two examples of these costs. Government spending on family support and early childhood programs benefits society as a whole—supporting the best interests of children is the right approach. Extensive research shows that this is the most cost-effective way to reduce poverty, encourage economic growth and build strong and supportive communities.[49]

Recommendation 2:

That the Ministry of Social Services and Yorkton Tribal Council Child and Family Services Inc. ensure high quality child protection casework by implementing:

- a formal process to measure staff competence in the use of SDM® tools;
- a formal process to measure competence in supervision; and
- a standardized supervision tool to assess whether casework policy standards are met.

The SDM® tools alone do not ensure high quality child protection work. SDM®'s effectiveness hinges on staff competence in use of the tools. This not only requires training in the tools, but evaluation of competence in their use. In many complex roles and systems, professionals must demonstrate competency in order to practice (physicians, airline pilots, engineers, and teachers) and child protection should be no different.

Strong supervisory skills and oversight are critical to building staff competence. A standardized tool would equip supervisors to transfer their knowledge to front-line workers, promoting better outcomes for children and families.

Recommendation 3:

That the Ministry of Social Services contract with the Children's Research Centre to complete an SDM® workload estimation study that determines standards for caseload size in Saskatchewan. Once the study is completed, implement the recommended standards.

Supervisors and caseworkers involved with these boys and their families reported to the Advocate that workload demands hindered their ability to comply with policy. The implementation of SDM®, particularly the increased contact standards, has compromised the ability of workers and supervisors to meet the standards set out in policy.

Recommendation 4:

That the Ministry of Social Services amend policy to require a case conference with all key service providers involved with a family within the initial Assessment and Case Plan timeframe (90 days) and thereafter as necessary.

When a family has an open protection file, MSS must take the lead to ensure services meet identified needs, are coordinated and achieve the intended outcomes. Case conferences are a forum for this integration of

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48. Saskatchewan Community Resources and Employment / Montreal Lake Child and Family Agency Inc. The "Baby Andy" Report: Examination of services provided to Baby Andy and his family. July 2003. Available at: http://www.socialservices.gov.sk.ca/BabyAndy-report.pdf

49. World Health Organization. Closing the Gap in a Generation: health equity through action on the social determinants of health. Commission on the Social Determinants of Health. Geneva, 2008. Available at: http://www.who.int/social_determinants/thecommission/finalreport/en/. See also footnote 39.

planning and services. A policy standard that formalizes this collaboration with other service providers will improve the quality of MSS's work with children and families.

Recommendation 5:

That the Ministry of Social Services strengthen its policy to ensure that scheduled family visits are maintained. The following standards should be embedded in policy:

- documented supervisory review when a visit is cancelled
- rescheduling cancelled visits as soon as possible when in the best interest of the child

Children have a right to family and, when it is safe and in their best interest, this includes the right to regular contact with parents and siblings. For children in out of home care whose parents are working to reunify the family, these visits are critical to maintain the parent-child bond and assess the potential for reunification.

Recommendation 6:

That the Ministry of Social Services, in consultation with the Children's Research Centre, amend their Safety and Risk Assessment tools to ensure they support the assessment of each parent's household when parents live apart but there is joint legal custody.

While *The Child and Family Services Act* and MSS policy speak to preserving and maintaining families whenever possible, the SDM® tools and sections of policy guiding investigation and apprehension do not explicitly guide workers through the process of assessing safety and risk when a child is part of two households. Clarifying policy and embedding consideration of joint custody situations in the assessment tools will ensure that both legal parents are considered before children are placed in out of home care.

Recommendation 7:

That the Ministry of Social Services research and implement methods for evaluating the quality of case practice and the outcomes of services for children and families.

The current quality assurance practices are focused on compliance to policy, not outcomes. MSS needs to equip itself to answer the question: do child and family outcomes improve as a result of their services? To build on the Child Welfare Review recommendations, an improved quality assurance mechanism will be an important factor in the development of an accountability framework.

Recommendation 8:

That the Ministry of Social Services conduct compliance reviews on First Nations Child and Family Services agencies on a yearly basis, rather than the current practice of every three years.

Agencies should receive the same level of support and oversight as MSS regional service areas to achieve compliance with policy standards.

Recommendation 9:

That the Ministry of Social Services ensure Child Death and Critical Incident Reviews are comprehensive and include a review of services provided to the child by other service systems. The Ministry of Social Services should consult with these bodies about the development of protocols for information sharing when conducting these reviews.

These boys were receiving services from multiple systems. Protocols would help the reviewers obtain timely and comprehensive information to assist in development of recommendations aimed at improving the integration of services and continuity of planning.

Recommendation 10:

That Regina Qu'Appelle Health Region examine whether the criteria for initiating incident reviews of various types need to be adjusted, in light of their experience with Derek's case.

It appears that the current Child and Youth Services review criteria exclude circumstances in which an individual receiving mental health services commits serious harm to someone else, and that no other comprehensive interdisciplinary incident review occurred in a timely way.

Recommendation 11:

That the Ministry of Social Services and the Ministry of Health and their related agencies conduct joint critical incident reviews for children and youth served by both the Ministry of Social Services and the Mental Health and Addictions system within the preceding twelve months.

Joint reviews would provide an opportunity to identify and address broader systemic issues, including access to and co-ordination of services, in order to determine what could have been done to prevent the critical incident, or to prevent similar incidents in the future.

Recommendation 12:

That the Ministry of Social Services and Yorkton Tribal Council Child and Family Services Inc. develop the protocols identified in their Agreement but not yet in place. Of these, the following protocols should receive immediate priority:

- staff training, development and support
- child abuse investigations
- integrating health, education and family services

The current Agreement with this Agency is broadly worded and does not provide specific information about the roles and expectations of each party for the delivery of a child welfare program. Protocols would provide this clarity for both parties.

Recommendation 13:

That the Ministry of Social Services increase its knowledge and understanding of Yorkton Tribal Council First Nations Child and Family Services Inc.'s operations to better support their capacity to deliver quality services.

Until the recent Critical Incident and Quality Assurance Reviews, MSS did not have detailed information about the operations of the Agency, particularly with respect to its protection and prevention programs. More comprehensive information and open discussions with the Agency about its challenges would have provided the opportunity to work with the Agency to address some of its issues.

Recommendation 14:

That Yorkton Tribal Council First Nations Child and Family Services Inc. fully develop its database system to make all current and historical information accessible to staff that require it.

Staff did not have access to important information about the Agency's involvement with Derek and his family, therefore risk was not appropriately assessed and services were not provided.

Recommendation 15:

That Yorkton Tribal Council First Nations Child and Family Services Inc. develop policy to create and clarify a working relationship between prevention and protection programming.

The disconnect between prevention and protection programming impedes the sharing of important information and recognition that a family's level of risk warrants a protection response.

Recommendation 16:

That the Ministry of Social Services and Yorkton Tribal Council First Nations Child and Family Services Inc. provide written progress reports to the Advocate on the applicable recommendations within three months of the release of this report and every three months thereafter for a period of one year.

The Advocate has the authority to advise government and provide independent oversight of its services. All children have the right to be safe and to live in families. These cases illustrate the urgent need for MSS and the Agency to improve the quality of child and family services. The Advocate's requirement for ongoing reporting reflects this urgency.

Recommendation 17:

That the Ministry of Social Services, Ministry of Health and Regional Health Authorities jointly develop mental health and addiction services to ensure immediate access to mental health and addiction services for high risk families with child protection involvement.

Complex stressors and multiple risk factors bring families to the attention of the child protection system. Mental health issues and substance misuse are major contributors. These factors impacted both families, neither of whom had timely or reasonable access to treatment, counselling and programs to address their needs. Navigating service systems is challenging and outreach services benefit vulnerable families.

Recommendation 18:

That the Ministry of Social Services, the Ministry of Health, and Regional Health Authorities expand outreach and intervention programs for children with FASD.

Government support for children with FASD and their families is inadequate in our province, particularly in remote and rural communities. In Derek's case, an assessment was completed, but there were no local resources to assist with intervention. Expanding outreach in these communities will address current unmet needs and the urban rural disparity.

Children living on reserve are entitled to the same standards of health and education services as all other children in the province. Achieving this right will require collaboration with First Nations leaders and the federal government, who funds services for families on reserve. ◆

11. CONCLUDING COMMENTS

The stories of Sam and Derek illustrate significant gaps and shortfalls in the services delivered by MSS and this Agency. The lives of these boys intersected in a tragic way and we have much to learn from their experiences. A common theme found in their histories related to the provision of services to support their families to care for their children. MSS put outside resources in place for Sam, but there were issues and delays with the services provided to his parents.

For Derek, the Agency did not adequately respond on many occasions to child protection reports. When the Agency did respond, they did not properly assess the risk to Derek's safety and well being. Early on, intervention services that could have helped his family were either not offered, or not coordinated and monitored. Further, health services to support children living with FASD were not accessible in Derek's community and outreach services are limited. By the time that matters became much more serious, the focus was on Derek, and little was done to help his parents support his needs.

No child deserves to have their life ended as Sam's did. At the same time, no child deserves to have his needs ignored as Derek's were

With respect to the Agency, much work needs to be done to improve their services. I look forward to working with the Agency to bring about the changes needed to help their families.

The evidence we gathered leads the Advocate to suggest that Sam's death may have been preventable. Had MSS ensured that services were provided to his family in a timely manner, Sam may not have been in MSS's care or might have returned home sooner. Had the Agency provided much-needed supports to Derek and his family, he may not have been unsupervised on the evening of August 21, 2013, when Sam came to his community.

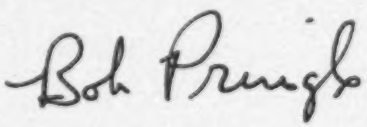
Derek appears to be getting the quality of care he needs now and his needs in this regard will likely continue through most of his life. Both sets of parents will likely need support into the future. This case is a double tragedy in that sense. In presenting this report, we acknowledge that Derek may need our ongoing advocacy as he moves on through his life. He has not, and cannot, been convicted of any offence related to this incident and that must be respected by all concerned.

The people of Saskatchewan expect that child protection and health services provided to vulnerable families are of the highest level of quality. Canada has signed international protocols to ensure this occurs. The Government of Saskatchewan has adopted the *Children and Youth First Principles* based on these international protocols. This investigation has demonstrated that much more needs to be done in this regard. Failure is not an option when it comes to the lives of children and parents at risk. As this case demonstrates, the cost of untimely and inadequate services is enormous.

No child deserves to have their life ended as Sam's did. At the same time, no child deserves to have his needs ignored as Derek's were. We have made strong recommendations to improve the casework of both MSS and the Agency who provided services to these boys and their families. My office intends to be vigilant to ensure these recommendations are implemented.

I wish to thank all those who contributed to this investigation. We share the common view that improvements to our child welfare system are in the best interests of all children and youth in Saskatchewan.

This report is dedicated to both boys and their families.



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